University Hospitals of North Midlands NHS Trust

Policy No. C33
Trust Policy for the Use and Reduction of Restrictive Interventions including the use of Clinical Holding Skills (CH-3^{SM})

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **Local Security Management Specialist (LSMS)**
- **Chief Nurse**
- **Senior Nurse Safeguarding**
- **All Medical Staff**
- **All Nursing Staff**
- **All Allied Health Professionals**

Version:	**2**
Ratified By:	**Quality and Safety Forum**
Date Ratified:	**July 2018**
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Date of Review:	**July 2021**
Trust Contact:	**Senior Nurse Safeguarding**
Executive Lead:	**Chief Nurse**

Statement on Trust Policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands NHS Trust aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.'

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Act 2018, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the "right and freedom" of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of complaint. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act
Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections

The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.

The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights

The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development

The University Hospitals of North Midlands NHS Trust recognises the impact that its operations have on the environment as well as the strong link between sustainability, climate change and health. The trust is committed to continual improvement in minimising the impact of activities on the environment and expects all members of staff to play their part in achieving this goal and in particular to work towards a 10% carbon reduction by 2015. The Green Aware Campaign is designed to support you to do this. All trust policies should embed sustainability and refer to our Sustainable Development Management Plan where relevant. Further information and guidance can be obtained from the Trust Sustainability Manager.

Version Control Schedule

Final Version	Issue Date	Comments
1	December 2015	New Policy
2	July 2018	Amendments include: Ensure post incident debrief occurs for the patient where appropriate; Use of mittens are the only form of mechanical restraint advocated by the Trust; ACN – Ensure it is determined on an individual basis if the patient requires a clinical member of staff or a Security Officer; Sisters / Charge Nurses / Matrons – ensure that when security officers are utilised that a qualified member of the nursing team continues to take overall responsibility for the patient; Ensure a copy of the DoLS request is retained in the patients notes.

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1. INTRODUCTION

The Trust is committed to providing a safe environment for its patients, staff and other users. It is recognised that there is a need to have effective policy and practice in place to manage challenging behaviour in vulnerable adult patients, therefore this policy has been produced in support of Trust Policy EF15: Management of Violence and Aggression at Work: Appendix 5: (Unacceptable Behaviour Flowchart). The Positive Options framework (2011) has been used to inform this policy in order to provide information and guidance on the use of Clinical Holding and sedation of vulnerable adult patients within the Trust. The term Vulnerable adult, as used within this policy, describes adult patients who have a clinical condition/ mental health issue or disorder predisposing them to aggressive behaviour.

The use of Clinical Holding is always an emotive issue, however, the Trust recognises that violent and aggressive behaviour in the vulnerable adult patient can escalate to the point where Clinical Holding and/or sedation may be required to protect the person, staff or other legitimate users of Trust premises/facilities from significant injury or harm, even if all best practice to prevent such escalation is deployed.

It is acknowledged that decisions on the use of Clinical Holding methods to be applied to vulnerable adult patients in urgent and emergency situations may have to be made quickly and without consultation with colleagues. Sometimes such Clinical Holding may lead to complaints by patients or their relatives.

The use of Clinical Holding with the vulnerable adult patient is a last resort intervention, to be used only when all other interventions have been unsuccessful. Used inappropriately it can be classed as a form of abuse and potentially lead to criminal proceedings. If Clinical Holding and/or sedation is used it should be carefully monitored.

This policy should be read in conjunction with the following documents:

- Nursing & Midwifery Council (2008) The Code: Standards of conduct, performance and ethics for nurses and midwives.
- Trust Policy C 17b Duty Rota Administration and Staff Rostering for Nursing, Midwifery and Allied Health Professionals
- Trust Policy EF 15 *Appendix 5: Flowchart for Management of Unacceptable Behaviour.* Management of Violence and Aggression at Work UHNM
- Trust Policy C 08 Therapeutic Observation (Specialling) of Adult Patients who are considered a risk of harm to themselves or others
- Trust Policy C 36 Protection of Vulnerable Adults from Abuse
- Positive Behaviour Management: A Policy Framework for Restraint Reduction for Services That Work With People (2011) positive-options.com
- Trust Policy C43 Policy and Procedure for obtaining consent
- No Secrets (2002) Department of Health, HMSO: London
- Adult Protection: Preventing Abuse of Vulnerable Adults (2004). Social Services, Health and Police Partnership with Commission for Social Care Inspection.
- NHS Protect '*Meeting needs and reducing distress: Guidance on the prevention and management of clinically related challenging behaviour in NHS settings*' http://www.reducingdistress.co.uk/reducingdistress.
- Integrated Dementia Care Pathway available on the Intranet
- Care Act (2014) Department of Health, HMSO: London

An Equality Impact Assessment has been completed and shows that this policy has no negative impact on equality.

2. POLICY STATEMENT

The Trust is committed to providing a safe environment for its patients, staff and others, as well as recognising the needs and respecting the dignity of the individuals for whom it provides care. The Trust is committed to improving standards of care and delivering a service that is of the highest quality possible. This includes ensuring there is a system of monitoring in place applicable to patients needs and responding to alterations in risk, whilst being cost effective and efficient.

This policy aims to provide information and guidance on the management of patients who are being resistive to care and/or treatment. Its aim is to help all involved act appropriately and in a safe manner, thus ensuring effective responses in potential and 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 considered.

The Trust acknowledges that there will be occasions when an individual's behaviour necessitates the use of Clinical Holding, however, the overall aim is to reduce the need for restrictive intervention.

The Trust aims to act with dignity and respect when dealing with difficult and challenging behaviour. It should be managed with the rights of the individual, balanced against the risk of harm to patients, staff and members of the public. The clinical holding of any aggressive person **by physical means should only be used when it is reasonable to do so and all other alternative therapies have been exhausted. It should be proportional to the risk of the situation.**

The Trust provides assurance that clinical Holding will only be implemented when all other practical means of managing the situation have failed or are judged likely to fail in the circumstances. For example; de-escalation, verbal persuasion and effective communication, or gaining consent to taking medication. All Trust staff are required to undertake Conflict Resolution training. The self-respect, dignity, privacy, cultural values, race, and any special needs/vulnerability of the patient should be considered in so far as is reasonably practicable.

The Trust has systems and processes in place to review all incidents where clinical holding is instigated, to ensure that any restrictive intervention used is **reasonable, proportionate and necessary. See Appendix 5, Risk assessment record + clinical decision making tool when considering the use of clinical holding therapies.**

The physical holding of a patient is only to be undertaken following a risk assessment by a member of staff that has been trained and deemed competent in CH-3, or has equivalent experience in the management of challenging behaviour.

The Trust will ensure that professional and legal support is made available to any member of staff acting lawfully and in good faith, in situations where aggression or violence (actual or threatened) have led to clinical holding being applied.

The Trust will ensure that staff have access to occupational health services and staff support services following incidents where violence and aggression have had a physical or psychological impact, see Appendix 10.

3. SCOPE

This policy applies to all staff working within the University Hospitals of North Midlands NHS Trust regardless of contract type. It also applies to those who are employed by the contracted agencies of the Trust including; independent contractors, students on placement and volunteers.

4. DEFINITIONS AND GUIDANCE

- **Mental Capacity**
  The Mental Capacity Act 2005 sets out the legal definition of the status of an individual who **lacks capacity.**

  A person is unable to make a decision for himself if he is unable to:-

  a) Understand the information relevant to the decision
  b) Retain that information
  c) Use or weigh that information as part of the process of making the decision, or
  d) Communicate his decision (whether by talking, using sign language or any other means)

- **Deprivation of Liberty Safeguards (DOLS) -** A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'.

- **Best Interests** are when decisions are made by the Health Care Professional to act on behalf of the patient to preserve life, health or well-being, when they are not competent to do so.

- **Vulnerable adult** as used within this policy, describes adult patients who have a clinical condition/ mental health issue or disorder predisposing them to aggressive behaviour. See Appendix 7 and 8.

- **Restraint** There is no precise legal definition of what constitutes restraint but in broad terms means restricting someone's liberty, preventing them from doing something they want to do. For the purpose of this document, restraint should be viewed as an intervention that prevents a person from behaving in ways that threaten or cause harm to themselves, to others or to property.

- **Physical Restraint** is any manual method, physical or mechanical device, material, or equipment that immobilises or reduces the ability of a person to move their arms, legs, body or head freely.

- **Chemical Restraint/Sedation** is the use of medication to manage a patient's extremely violent or aggressive behaviour. Administration, if necessary, may be given against the patient's wishes if they lack capacity and it is deemed in the patient's best interest. 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 or harm is less immediate. When caring for patients with Dementia, use of the antipsychotic checklist found in the Integrated Care Pathway (available on the Intranet) is advisable.

- **Imminent Danger** is 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.

- **Person in Charge** is the most senior or appropriate person in an area/ward, who takes responsibility for managing a threatening situation.

- **Objective of Restraint** 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).

- **CIWA-Ar** scale is a guide to assessing the severity of withdrawal symptoms, available via clinical guidelines on the intranet

- **CH-3^{SM} (formerly MAPA)** is a formal two day training programme that aims to train staff in the use of therapeutic holding techniques, in situations where patients are resistive to assessment/treatment. Target areas within the UHNM Trust for CH-3^{SM} training are aimed at staff working in high risk areas.

- **Debrief** is used generically as a way of describing the need for the person, staff, and others to take 'time out' to reflect on the situation that has occurred and learn from it – ideally within 24 hours following an incident. Longer-term, more intensive support may be required in some scenarios.

- **Control Mittens** These are a safe form of restraint which restricts movement - after looking at least restrictive options, these are sometimes utilised (following a formal process) to reduce the patients tactile ability, always used in conjunction with discussions with next of kin please see Appendix 4.

- **Duty of care** All health care staff have a duty of care for the patients in their care. This means acting in their "best interest". In relation to a patient who is at immediate risk of harm, restraint may be part of the duty of care.

  Four main ethical principles should be respected where possible when considering our duty of care, although it must be acknowledged that these principles may be in conflict with one another. We should always:

  - Intend to do the patient good (beneficence)
  - Intend to do the patient no harm (non-maleficence)
  - Treat all clients fairly and equally (justice)
  - Aid and respect the patient's right of self-determination (autonomy)

- **ATC (Approved Training Centre)** the co-ordinator is the Senior Nurse, Safeguarding

- **CI (Certified instructor**) – Staff who have attended approved training by CPI to deliver CH-3^{SM} training.

Unacceptable Methods of Restraint (MUST NOT BE USED)

- **Elevated bed height**. It increases the risk of injury resulting from a fall out of bed. Patients are occasionally nursed on low beds to reduce the risk of harm should they fall. A low bed is acceptable when appropriately risk assessed.
- **Wheelchair safety straps**. The straps on wheelchairs should always be used however these are used for patient safety and not as a means of restraint.
- **Reclining Chairs**. Reclining chairs should be used for the purpose of patient comfort and not as a method of restraint.
- **Locked Doors**. Doors should not be "locked" in an acute care setting; coded locks and push button exits are excluded.
- **Arranging furniture to impede movement**. Any equipment/furniture included is to be used for its intended purpose only. Using furniture to impede movement increases the risk of falls through trips.
- **Removal of walking aids, outdoor shoes, and sensory aids such as spectacle/hearing aids**. This can cause confusion and disorientation. Increases the risk of patient harm from falls.
- **Bed rails**. Should only be used when a risk assessment has been completed and their use is to maintain the safety of the patient.
- **Isolation**. Isolation in the acute care setting should be for the purposes of infection control or by patient choice only (Refer to infection control policy).
- **Mechanical Restraints.** The use of mittens is the only form of mechanical restraint advocated by the Trust following a risk assessment. Mechanical restraints such as

handcuffs can only be utilised by the Police / Prison Officer and when in use the Police / Prison Officer must be in constant attendance.

Manual Restraint considerations

- **Patients must never be restrained on the floor.**
- Do not use manual restraint in a way that interferes with the patient's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.
- Do not use manual restraint in a way that interferes with the patient's ability to communicate, for example by obstructing the eyes, ears or mouth.
- Undertake manual restraint with extra care if the patient is physically unwell, disabled, pregnant or obese.
- Aim to preserve the patient's dignity and safety as far as possible during manual restraint.
- Do not routinely use manual restraint for more than 10 minutes.
- Ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable and proportionate to the situation and applied for the shortest time possible.
- One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

    - Able to protect and support the patients head and neck, if needed.
    - Able to check that the patient's airway and breathing are not compromised.
    - Able to monitor vital signs
    - Supported throughout the process
    - Monitor the patient's physical and psychological health for as long as clinically necessary after using manual restraint.

5. ROLES AND RESPONSIBILITIES

The following personnel have direct roles and responsibilities in the implementation of this policy.

5.1 Chief Executive

- To ensure the provision of adequate resources to enable effective implementation of this Policy
- To maintain effective reporting mechanisms into the Board in connection with this Policy

5.2 Chief Nurse

- To ensure the provision of adequate training resources to enable the effective implementation of this policy
- To monitor decisions made under the Management of Challenging Behaviour in Vulnerable Adults
- To create and maintain effective reporting mechanisms into the Board in connection with this policy

5.3 Associate Chief Nurses

- To manage and organise Divisional resources to enable effective implementation of this policy which may include provision of extra clinical or security staff, on some shifts for some patients. It must be determined on an individual basis if the patient requires the presence of a clinical member of staff or a security officer.

- To monitor and review divisional performance in connection with this policy
- To report issues related to the implementation of this policy via the divisional governance structure

5.4 Medical Staff

- Liaise with nursing staff to identify and review the level of restraint, if any, for patients using the assessment criteria.

5.5 Sisters/Charge Nurses, Matrons and Nurse Practitioner

- To work together with medical staff and the multidisciplinary team to identify, instigate and review the level of any physical restraint used.
- To ensure any restraint used is amended appropriately according to the patient's needs.
- To carefully consider requests for additional resources to assist in alleviating constraints as a result of Challenging Behaviour incidents
- Agency or bank staff should not be routinely allocated to provide the role of Person in Charge
- To ensure that if a patient requires the presence of a security officer that a qualified member of the Nursing Team continues to take overall responsibility for that patient.
- To ensure DATIX forms are completed (including the 'recording restraint' section), reviewed and action plans implemented immediately
- To ensure that methods of post-incident support, including supporting referrals for more formal debrief or counselling for staff assessed as needing it, are operationalised

5.6 Local Security Management Specialist (LSMS)

- To liaise with Sodexo Security Manager (RSUH) and the Operational Security Manager (County Hospital) regarding 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, Police & Crown Prosecution Service (CPS) as necessary.
  Liaise with NHS Protect Legal Protection Unit (LPU) and the Police in accordance with Secretary of State Directives
- Provide advice on care-planning in relation to potential AVH incidents.
- Be part of the de-brief and any subsequent follow up.

5.7 Senior Nurse for Safeguarding

- As part of the Safeguarding Team the post holder will contribute to the setting, monitoring and maintenance of robust safeguarding adult arrangements and training programmes. She/he will contribute to collaborative interagency working and quality assurance frameworks for safeguarding.

- The post holder will provide expert clinical leadership and direction for the safeguarding of adults with care and support needs within the UHNM.

- The post holder will provide supervision and support to all staff re safeguarding adults particularly the complexities of statutory requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

- The role will include advising UHNM on its duties for Safeguarding Adults with care and support needs as stipulated by government strategy and national, regional and local guidance.

5.8 The member of staff identifying the violent or aggressive behaviour or intent will

- Report 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 diffuse the situation by reassurance and other acceptable methods, for example diversional activities.
- If possible, remove harmful objects from immediate area.

5.9 The Person in Charge will

- Following the completion of a Risk Assessment Record, (see Appendix 5), assume the lead role for any clinical holding that does take place, if determined that it is justified and appropriate.
- If they consider necessary, request assistance from Security in the first instance. If staff are in fear for their safety the Police should be contacted stating “we are in fear of our safety”.
- Have a sufficient understanding of restraint processes, of the law, and of this policy, to ensure a satisfactory outcome for all involved.
- Where it is believed that we are depriving a patient of their liberty completion of both an urgent and standard DoLS authorisation form is required (Appendix 3)
- Inform appropriate medical staff and the Nurse Practitioners with appropriate urgency.
- Ensure that wherever possible de-escalation techniques are used throughout a restraint process.
- Ensure a care plan is in place whilst the patient is receiving clinical holding (see Appendix 6), remembering to regularly assess the need for continued clinical holding.
- Arrange for the family, friends or carer to be contacted/be involved if it is thought they may have a calming influence on the person.
- Ensure the incident is reported via the adverse incident reporting system (Datix) in accordance with Trust Policy including the completion of the ‘recording of restraint’ section.
- Arrange and lead the de brief, and participate in any subsequent follow up and support. Conducting a post-incident debrief helps the organisation to identify and address any physical harm to service users or staff, on-going risks, and the emotional impact on service users and staff. The patient involved in the incident should be offered the opportunity, where appropriate, to contribute to the immediate debrief and discuss the incident with a member or staff, an advocate or a carer. This debrief should take place as soon as possible after the person has recovered their composure. This gives them the opportunity to give their perspective of the event and understand what happened.
  Note: if the person in charge is also involved in the incident then they may wish for their line manager to lead the debrief.

5.10 Senior Sisters/Charge Nurse should

- 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.
- Ensure risk assessments are undertaken to establish whether frontline staff are required to attend Clinical Holding Training (yearly) or Conflict Resolution Training (3 yearly, refreshed annually via E-Learning), and to ensure attendance is facilitated and training is undertaken.

- Ensure appropriate Management Plans are in place for all Patients who have been assessed as posing a high risk of violence, aggression and harassment. All such plans must be brought to the attention of all relevant staff
- Use appropriate resources for minimising the risk of violent incidents; for example CIWA – Ar proforma (Appendix 9), workplace violence risk assessment (see policy EF15).
- Ensure any staff that are involved in (or witness to) restraint, are offered support, either via the Occupational Health Department, or Staff Support (Appendix 11)

5.11 Adult Safeguarding Working Group

Members of the Adult Safeguarding Working Group, together with Associate Chief Nurses, Matrons and Human Resources are responsible for ensuring this policy is accurate, up to date and is understood by all staff. The Adult Safeguarding Working Group will also review safeguarding concerns that involve incidents covered by this policy.

All staff should be familiar with the contents of this policy including the further guidance and procedural information in Appendix 1.

6. Education and Training

This Policy promotes on-going education, training and awareness of the issue surrounding management of aggression and the use of clinical holding (CH-3). It is the responsibility of managers to identify if this training is required. All staff are responsible for attending Conflict Resolution Training and to follow through with refresher sessions every three years. Information for this training is available on the intranet. In high risk areas, such as Emergency Portals, staff are responsible for ensuring their competence in CH-3; training is accessed via ESR.

Information about this policy is posted on the intranet

Training should be held in the staff personal record, ideally within ESR.

7. Monitoring and Review

7.1 Monitoring

Regular monitoring will take place to give assurance to the Quality & Safety Forum via the Adult Safeguarding Working Group that there is compliance against the policy. This will include:

- Monitoring of incident reporting via Datix, by Senior Sister, Matrons and LSMS.
- Monthly reports to the Senior Nurse Safeguarding from Security Manager (Sodexo) when Security Officers have been requested.
- Regular review of completed Monitoring Forms following a Clinical Holding Incident.

7.2 Review

The effectiveness of the policy will be reviewed and the policy modified, as necessary, after 3 years or sooner if legislation changes.

8. References

- Management of Violence and Aggression at Work Policy EF15
- Health and Safety at Work Act 1974
- Mental Capacity Act 2005

- Trust Policy C 17b Duty Rota Administration and Staff Rostering for Nursing, Midwifery and Allied Health Professionals
- Trust Policy EF 15 Appendix 5: Flowchart for Management of Unacceptable Behaviour. Management of Violence and Aggression at Work UHNM
- Trust Policy C08 Therapeutic Observation (Specialling) of Adult Patients who are considered a risk of harm to themselves or others
- Trust Policy C36 Protection of Adults from Abuse and Neglect who have Care and Support Needs
- Positive Behaviour Management: A Policy Framework for Restraint Reduction for Services That Work With People (2011) positive-options.com
- Trust Policy C43 Policy and Procedure for obtaining consent
- Resuscitation Policy C09
- The Positive Options framework (2011)
- American College of Critical Care Task Force (2001/2)
- Policy for Restraining Therapies within the Acute Hospital setting for Adult Patients
- Violence and aggression:short-term management in mental health, health and community settings. NICE guideline. May 2015
- Positive & Proactive Care: reducing the need for restrictive interventions (2014)
- Trust Policy HR22 Supporting Staff involved in an Incident, Complaint or Claim

APPENDIX 1

University Hospitals of North Midlands
Clinical Holding (CH-3^{SM}) Monitoring Form

Patient Name:		**Date of Birth:**	
Unit No.		**NHS Number:**	
Consultant:		**Ward:**	
Date:			
Diagnosis:			

Clinical Holding Initiated by **……**

Name of other nurse consulted **……..**

Reason for use of clinical holding (e.g. patient behaviour interfering with the provision of necessary treatment, patient a danger to self / others, disruptive to the well-being of others, hyperactive leading to exhaustion).

Alternative to clinical holding tried (e.g. relative / nurse staying with patient, diversions such as music or going for a walk, conversation).

Time clinical holding commenced and exact location	**Time discontinued and exact location**

Details of interventions attempted prior to restraint

Reason for use

Breakaway technique to escape from a difficult situation ☐

Clinical holding – planned intervention ☐

Clinical holding – control of aggressive behaviour ☐

to other ☐

to self ☐

to property ☐

Details of all people involved:

Name	Grade	Role / Responsibility	Physical method used* Use key
		Head	
		Right arm	
		Left arm	
		Legs	
		Incident Co-ordinator	

***Key to methods used:**

1. **Physical holding not appropriate / required**
2. **Immobilisation**
3. **Immobilisation of an outstretched arm**
4. **Immobilisation of a bent arm**
5. **Immobilisation of the hand without flexion to the wrist**
6. **Taking over from a colleague**

Position
Please indicate all of the positions that the patient was held in during the process in column 1. The single position that was maintained the most during the process should be indicated in column 2.

	Column 1	Column 2
Sitting on a chair/sofa	☐	☐
Sitting on a bed	☐	☐
Sitting on the floor	☐	☐
Walking from one area to another	☐	☐

Use of protective clothing or other equipment:
Was it necessary for any member of staff to use any form of protective clothing or other equipment?

Yes **No**

Injuries occurring during the holding process

Patient	**Injury**	**Staff**
☐	No visible injury	☐
☐	Reddening/Bruising	☐
☐	Swelling	☐
☐	Lacerations/cuts	☐
☐	Abrasions/grazes	☐
☐	Scratches	☐
☐	Friction burns	☐
☐	Others - specify	☐

Subsequent Action:
"As required" medication given orally ☐
injection ☐

Patient must be reviewed immediately by a Doctor following clinical holding

Name of Doctor reviewing patient ……

Has the Doctor recorded his / her review in the medical notes **Yes / No**

Comments regarding the holding process, further details of any injuries sustained / use of protective equipment or any other relevant points should be recorded here:

Check List

1. **Use of clinical holding evaluation of its effectiveness, recorded in:**

Care plan

YES ☐ **NO** ☐

Medical Notes

YES ☐ **NO** ☐

2. **Nurse in charge of the ward informed**

YES ☐ **NO** ☐

3. **Consultant**

YES ☐ **NO** ☐

4. **Explanation given to the patient prior to use of clinical holding**

YES ☐ **NO** ☐

If "yes", who gave the explanation? ……

If "no", please give reason:

5. **Were the parents / guardian(s) / relatives / close friends* given the opportunity to discuss the use of clinical holding?**
***delete as appropriate**

Nursing staff

YES ☐ **NO** ☐

Consultant / Registrar

YES ☐ **NO** ☐

If "no" please give reason:

6. **Datix completed (Datix must be completed)**

YES ☐ **NO** ☐

Any relevant information (such as patient's or relative's positive or adverse comments concerning use of restraint and any subsequent action taken)

Staff Debriefing: Staff are encouraged to reflect with colleagues following incidents where clinical holding has been initiated. If staff feel they require addition support then they can contact the CI's (certified instructors).

Reflection with colleagues **Yes / No / N/A**

Contact with Certified Instructors **Yes / No / N/A**

Name of person in charge ……

Name of person completing form ……..

Signature …….....

Date of completion ……

On completion this form should be sent to either the Senior Nurse Safeguarding or Lead Preceptorship Nurse, c/o 2nd Floor, Springfield Building, Royal Stoke.

Key Issues for Patients who Lack the Capacity to Consent

The Mental Capacity Act 2005 sets out the legal framework for the treatment of patients who lack the capacity to consent or refuse treatment.

- **If it is determined that a patient lacks the capacity to consent or refuse treatment, a decision can be made as to how to proceed in the best interest of the patient.**
- **This decision is to take into account the least restrictive means of delivering care or treatment.**
- **Section 6 of the Mental Capacity Act defines restraint as the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists.**
- **Restrain is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person, and if the restraint used is proportionate to the likelihood and seriousness of the harm.**

APPENDIX 2

FURTHER GUIDANCE AND PROCEDURAL INFORMATION

Potential Risks of Restraint and Risk Assessment

The use of chemical or clinical holding can potentially cause adverse physical and psychological consequences (Micek et al (2005) Nirmalan (2004) and Watson, (2001).
In physical terms these include:

- Aspiration pneumonia
- Muscle atrophy
- Loss of bone density
- Nosocomial infection
- Strangulation
- Tachycardia and hypertension
- Pressure ulcers
- Limb injury
- Incontinence

Psychological effects include:

- Cognitive decline
- Emotional isolation
- Confusion and agitation
- Increased agitation and anxiety
- Depression and anger
- Loss of dignity and personal freedom to the patient
- Distress and feelings of shame for family members

Health care practitioners are responsible for ensuring that risk assessments are carried out on the use of restraint. Before the application of restraint an individual assessment should be carried out to consider:

- The environment
- Patient's behaviour
- Patient's underlying condition and treatment
- Patient's mental capacity
- Duty of care

Often behaviour such as wandering is problematic for staff; however this does not necessarily mean that preventing this behaviour is in the best interests of the patient concerned.

Having identified the reason for the behaviour, appropriate strategies should be discussed with other members of the multidisciplinary team and if applicable treatment of the underlying cause. This should be documented in the nursing/multidisciplinary notes with referral and discussion with the patient's consultant and family members (where appropriate).

Treat Underlying condition

Understanding a patient's behaviour and responding to individual needs should be at the centre of patient care. All patients should be assessed comprehensively in order to establish what sort of therapeutic behaviour management might be of benefit. This will involve identifying the underlying

cause of the behaviour (agitation, wandering, absconding etc.) and deciding whether the behaviour needs to be prevented. Possible causes to consider are:

- Hypoxia
- Hypotension
- Pyrexia
- Full bladder or bowel
- Pain or discomfort
- Electrolyte or metabolic imbalance
- Anxiety or distress
- Drug dependency or withdrawal
- Brain insult/injury or cerebral irritation
- Reaction/side effect of medication
- Intoxication (due to alcohol, drug overdose or drugs of abuse) please refer to Appendix 7- alcohol withdrawal assessment flow sheet
- Hallucinations, delusions, paranoia and personality issues
- Infection
- Dehydration
- Malnutrition
- Mental illness

If a patient's mental health is an issue, the Mental Health Services can be contacted for advice/support. Please see Trust intranet for details.

Therapeutic Approaches and Management Strategies

Therapeutic approaches used to reduce confusion and agitation includes a positive environment and good communication skills. Every effort should be made to reduce the negative impact of the environment which may include poor attitudes or poor communication skills of staff. Examples of environmental factors which can have a negative impact include: extreme staffing shortages impacting on quality of care or levels of supervision, restricted observation in patient areas, high levels of noise or disruption, boredom or lack of stimulation for patients.

Environment Strategies

- Provide a visible clock
- Minimise excessive noise and light
- Maintain a day-night routine
- Maintain a consistent Unit temperature
- Facilitate rest periods and also periods of patient activity
- Use diversional therapy – provide television/radio
- Use reminiscence with familiar objects from the patient's own home e.g. photos
- Reduce monitoring and lines as far as is practically possible
- Cluster care to avoid repeated disturbances

Communication Strategies

- Engage the patient in meaningful activity – ask the patient and/or relatives and carers what the patient likes to do, what they would be doing if they were at home etc.
- Orientate patient to time, person and place
- Reality orientation – use of diaries and memory aides
- Communicate clearly and concisely with the patient
- Provide repeated verbal reminders
- Identify and correct any sensory impairments i.e. glasses and hearing aid
- Maintain a patient's dignity
- Use empathetic communication and touch
- Involve a patient's family and friends in care

- Ensure continuity of staff
- Where the patient has known mental health issues or learning disability issues, refer them to the appropriate health care teams
- Provide communication aids

Clinical holding should only be used as a last resort and only when alternative methods of therapeutic behaviour management have failed, perhaps considering the risk of "doing something versus the risk of doing nothing". Its use should be proportional to the risk of the situation. The method used should be the least restrictive and be effective and safe. Inappropriate use of restraint may be viewed as a form of abuse. Restraint needs to be reasonable and proportionate; otherwise staff may face allegations of assault.

Staff have a moral obligation to do no harm; they need to balance the risks and benefits associated with all forms of restraint. Decisions should therefore balance the best interest of the patient to ensure safety and promote the patients well-being and safeguard their interest.

When all other alternative therapies have failed and as a last resort, it is deemed that there are situations where it would be seen as lawful to use reasonable force to restrain a patient

These are:

- To prevent self-harm or risk of physical injury
- Where staff are in immediate risk of physical assault
- To prevent dangerous, threatening or destructive behaviour
- To provide necessary assessment/treatment deemed in the patient's best interest

Any clinical holding used by a Health Care Professional is a potential exploitation of a patient's rights under the Human Rights Act (1998). Consequently Health Care Professionals, patients and their families may feel uneasy with the adoption of clinical holding. However, **Health Care Professionals also have a responsibility to act in the 'best interests' of an incapacitated patient and thus protect them from harm.**

Once the decision has been made to implement clinical holding the risk assessment and care plan should be followed (see appendix 3 & 4).
The decision to use 'Mittens', should be made after the completion of the relevant documentation, see appendix 2.

Discontinuation of clinical holding

Having implemented clinical holding the healthcare team must continually monitor for physical and psychological adverse effects. If the risks outweigh the benefits, then clinical holding must be stopped immediately. The effect of clinical holding or pharmacological restraint should be evaluated throughout, utilising the specified care plan (Appendix 4). The restraint should be discontinued at the earliest opportunity. This may be because the patient's behaviour no longer renders the need for clinical holding or that the clinical holding has worsened the patient's agitation. Reasons for discontinuation should be clearly documented.

APPENDIX 3

Standard Operating Procedure

Deprivation of Liberty Safeguards

Purpose:	To ensure that the correct process is followed when requesting authorisation of a deprivation of liberty for a patient at UHNM
Scope:	All in-patients at UHNM who are deprived of their liberty are done so with the authorisation of the Supervisory Body.
SOP Reference Number:	SOP-C33-001
Policy SOP Relates To:	C33 Use and Reduction of Restrictive Interventions including the use of Clinical Holding Skills (CH-3)
Date of Issue:	July 2018
Date of Review (Align to Policy Review Date):	July 2021
Version Control:	V2

1.	Where it is believed that we are depriving a patient of their liberty completion of DoLS application form comprising of urgent and standard DoLS authorisation is required.	DoLS application form can be found on the Trust intranet - please ensure that pages 1-7 are completed **Urgent** - This part of the form should be used if a Managing Authority (UHNM) needs to give itself an urgent authorisation to deprive a person of their liberty – 7 days maximum. Complete the extension request on the top of page 7 so that your urgent authorisation does not expire before the Supervisory Body has been able to assess the patient. **Standard** –This part of the form should be used to request a standard authorisation, including where an existing standard authorisation is coming to an end and the person's care or treatment still needs to be provided in circumstances that will amount to a deprivation of their liberty **Please ensure a copy of the above form is retained in the patients notes.**

2.	Forward completed form to the Supervisory body – the Supervisory body is determined by the patient's usual address.	**Stoke Residents –** Stoke BIA Team Tel: 0300 123 1461 Fax: 01782276435 email: stoke.dols@nhs.net **Staffordshire Residents –** Tel: 01785 895665 Fax: 01785895678 email: deprivationofliberty@staffordshire.gov.uk **Residence unclear – use the following website https://www.gov.uk/pay-council-tax to identify which local authority the patient's address sits under.** Please note if you are emailing your referral to one of the above please ensure that it is password protected
3.	E-mail completed form to dols@uhnm.nhs.uk and to your Clinical Matron	This is to ensure that UHNM can enter details onto a database and inform the Care Quality Commission.
4.	The Supervisory Body will contact the referring Ward and if they feel that the patient is being deprived of their liberty arrange an assessment of the patient by a BIA (Best Interest Assessor).	The assessment by the BIA is vital to protecting the rights of patients. Please note that if a BIA has not been to review your patient before your 7 day Urgent Authorisation has expired and you have not completed the extension request on form 1 you will need to contact the Supervisory body for an extension
5.	The Supervisory Body will inform the UHNM of their decision.	The authorisation is an important legal document and must be filed in the Patients notes. The authorisation might include conditions to which the managing authority (UHNM) and staff must adhere to make the deprivation of Liberty legal Should the BIA and Supervisory body not issue an authorisation then it is the managing authorities' responsibility to ensure that restrictions and / or restraints put on the patient do not deprive the patient of their liberty. Any recommendations given by the BIA and / or Supervisory Body should be followed.
6.	The Managing Authority has a duty to continually review whether or not a Deprivation of Liberty Authorisation is still required.	There are three circumstances under which this should be done: 1. There are changes to the patient's condition or arrangements. 2. The period of authorised deprivation is coming to an end. 3. The patient is being discharged.

7.	As soon as a Managing Authority thinks that they can look after the patient safely without the need to deprive them of their liberty, they should do so immediately	If the Managing Authority is not certain about the need for continued deprivation of liberty they should seek a review by the Supervisory Body by completing form 10.
8.	Ward to keep record of all DoLS requested and outcome following Supervisory Body assessment (see appendix 11). This form should be E-mailed to dols@uhnm.nhs.uk each month with the area Matron copied in.	This will ensure that the Trust has an accurate picture of the patients under a DoLS Authorisation in order that the CQC can be informed accordingly.
9.	If a patient dies whilst subject to a DoLS then Bereavement Services should be notified as they will need to inform the Coroner. The Supervisory Body will also need to be informed by completing form 12 in appendix 13 of the DoLS Policy.	This will ensure that the Authorisation is ceased.

Appendix 4

USE OF MITTENS TO PREVENT REMOVAL OF MEDICAL DEVICES

Patient Name: _____ **Date:**_____

Unit Number: _____ **D.O.B:**_____

Rationale: During a hospital stay the majority of patients will require the insertion or application of a medical device, for example a nasogastric tube for artificial feeding or a tracheostomy to assist breathing. During the acute period of their illness patients may be cognitively impaired and/or agitated, and may remove this device, on more than one occasion. This puts the patient at risk of harm, thus compromising their recovery.

Mittens can be used to help keep the medical devices that are being used in place, increasing patient safety and maintaining necessary assistance that will aid recovery. The mittens are specially designed for this purpose and are comfortable to wear and allow the skin to breathe. They can be applied to one or both hands. They should be removed for personal hygiene, therapy sessions involving the hand or arm, or to aid any other supervised activity carried out by the patient where the mitten would be a hindrance. The use of mittens should not be routine practice and will require careful discussions between the patient, relatives and responsible Consultant.

In order to decide if a patient has the capacity to make a decision to consent to the application of mittens, **the two stage test of capacity must be applied (document and circle the appropriate response in the box below):**

STAGE 1:

Does the person have an impairment or disturbance in the functioning of their mind or brain? **Yes** **No**

If the answer to this question is yes –

Is that impairment sufficient that they lack the capacity to make the decision to apply mittens? Go to stage 2.

STAGE 2:

Can the patient:

- Understand information regarding the proposed treatment, its purpose and why it is being proposed? **Yes** **No**
- Retain information for long enough to make an effective decision **Yes** **No**
- Use or weigh that information as part of decision making process **Yes** **No**
- Understand the benefits, risks and alternatives? **Yes** **No**
- Understand the consequences of refusal? **Yes** **No**
- Communicate his / her decision (whether by talking, using sign language or other means? **Yes** **No**

If the answer to any of these questions is NO the patient must be considered to lack capacity to consent to the treatment of mittens and completion of Box 2 is required

BOX 1 – Patients with capacity

Has the patient got capacity to consent to mittens? **Yes** **No**
If patient has not got capacity, go to box 2

If yes, has the purpose of mittens been explained to the patient? **Yes** **No**

BOX 2 – Patients without capacity

As defined in the 2 stage test of capacity, the patient does not have capacity to consent to the treatment of mittens:

1. Does the Consultant and the MDT agree that it is in the Patients' best interest to use mittens to maintain medical devices. **Yes** **No**

2. Have the patients next of kin or carers been spoken to about their views and the proposed treatment? **Yes** **No**

Name of next of kin / carer _____

Relationship _____

Signature _____

If Yes, document the discussion below:

Document rationale for use of mittens:

Name of person completing this form_____

Signature_____

Date_____

Copy to be retained in patients notes.

APPENDIX 5

RISK ASSESSMENT RECORD + CLINICAL DECISION MAKING TOOL WHEN CONSIDERING THE USE OF RESTRAINING THERAPIES

Name……
Hospital Number……
NHS Number……...
Consultant……
Date……..

This record must be used in the assessment, monitoring and evaluation of any patient who may require physical or chemical restraint in order to maintain the patient's own safety or to protect patients and staff from harm. However, restraint must be applied in the event of an emergency in the first instance and always in the best interests of the patient.

Does the patient behaviour have potential to endanger? (please tick, may be more than 1)			→ No → **Restraint Inappropriate**
Staff	**Self**	**Others**	

Yes ↓

Describe this behaviour: (this maybe a combination of factors)	**Yes**	**No**
Wandering and may decide to leave the ward		
Falling more than once		
Confused and /or disinhibited		
Agitated/Aggressive/ (may accidentally remove lines/tubes, climbing out of bed)		
Resistive to assessment/treatment		

Or

Repetitive removal of non-life threatening medical devices (please tick, maybe more than 1)			
IVI Peripheral		Dressings	
NGT		O2 Mask	
Catheter		PEG	
Drains		Epidural	

Potential removal of any one of these life sustaining devices/treatments			
CPAP		Chest Drain	
Inotropes		Arterial Line	
CVP		ICP Monitoring	
EVD/Lumbar drain		Tracheostomy	

↓

Identify any Reversible Causes and Treat
Pyrexia, Hypoxia, Pain
Withdrawal (nicotine, drugs, alcohol –CIWA score)
Bowel/Bladder
Fear, anxiety
Communication, memory impairment

Strategies to consider	**Yes**	**No**
Review drug therapy		
Diffuse situation/use of minimum of staff		
Utilise verbal de-escalation techniques		
Remove harmful objects		
Involve family or significant others		
Provide orientating stimuli (clock, newspaper, radio)		
Utilise direct observation (1:1)		
Diversional activities (music, T.V.)		
Optimise environment		

Is the assessing nurse able to maintain patient safety through the above strategies?

NO ↓ YES

Patient settled and outcome successful
Document strategies used/inform MDT

Patient remains unsettled

↓

Inform medical team of potential need for form of restraint and document

↓

Has assessment been documented of patient's Mental Capacity And Best Interests by duty Medical Team/MDT? Patient wishes/Relatives?	Date	Time

↓

In view of above decisions and current management plan.
Is restraint appropriate?

Yes ↓ No ↓

Decision making by Duty Medical/Senior Nursing or Therapy staff of safest, **least restrictive option** regarding type of clinical holding to be selected in accordance to individual patient's condition and situation specific.

↓

Identify least restrictive restraint to be used (please tick, may be more than 1)	
One to one supervision	
Appropriate use of Bed Rails	
Appropriate use of clinical holding	
Appropriate use of Mittens	
Appropriate use of Pharmacological Restraint	

→

See Medical Guidelines

Document clinical reasoning

- **~~Aggressive and violent~~ patients**
- **Acute confusional state**
- **Ensure maximum daily dose is specified**

←

The Care plan must now be implemented, see appendix 6

↓

Continue overleaf

	Print Name	**Date**	**Time**
Commence Care Plan			
Date and time restrictive measures implemented			
Signature of risk assessor			
Signature of senior nurse in charge			

Relative/Carer informed regarding use of identified			

Repeat and review risk assessment to ensure that restraining measures remain the most appropriate least restrictive option

To be filed in the Nursing Records

APPENDIX 6

CARE PLAN FOR THE USE OF RESTRAINING THERAPY

Type of restraint applied:
(E.g. mittens or sedation)

Name……
Hospital Number…….
NHS Number……...
Consultant……
Date……..

Undertake the following interventions	**Recommended Time Intervals**	**Date/time Initial**	**Date/time Initial**	**Date/time Initial**	**Date/time Initial**
Monitor Respirations Pulse, BP & oximetry Check Skin integrity & circulation Offer hygiene and toileting Offer food and fluids	15 minutes for 1st hour				
	If agitated continue every 15 minutes				
	If settled every 4 hours				
If mittens are applied wash, dry hands thoroughly Check fingernails	At least once every 8 hours				
Consider removal of invasive lines etc.	At least once every 8 hours				
Assess on-going need for restraint	At least once every 8 hours				
Document in the nursing notes	At least once every 8 hours				

TO BE FILED IN THE NURSING RECORDS

APPENDIX 7

Level of Therapeutic Observation Descriptors

There are 4 defined levels of therapeutic observation.

Level 1: General Therapeutic Observation

The location of the patient should be known to staff at all times, but they are not necessarily within sight.

- At least twice per shift, the patients allocated registered nurse will endeavour to communicate with the patients and an entry of the outcome of any assessment will be made in the patients nursing notes/medical records.
- The use of comfort rounds is the vehicle by which this can be monitored and recorded.
- At the beginning and end of every shift the whereabouts and general condition of all patients should be part of the handover.

Level 2: Intermittent Therapeutic Observation

This is an increased level of observation for patients, who after assessment, may be deemed to be a potential risk of disturbed and/or violent behaviour and/or fall. This may include those who have a history of previous risk but are in the process of recovery. Patients assessed to be within this category should have a special observation" care plan which should clearly indicate:

- The intervals at which observations should be carried out. Exact times should be specified in the care plan
- The need for an assessment by the registered nurse of the patient on each shift and a summary of the patient's behaviour, physical and mental state should be recorded in the nursing records / patient notes at the end of each shift. All staff on that shift and those who are responsible for the intermittent observation should be consulted prior to taking over and handing over care to the next shift.

Level 3: Within Eyesight Therapeutic Observation

Following a risk assessment, these patients are liable to make an attempt to harm themselves or others at any time. They may be "at-risk" of absconding or are considered to have an unstable physical or mental condition which may deteriorate and requires continuous assessment.

- They should be within eyesight and accessible at all times, day and night. These special observations are carried out on a one nurse to one patient basis. They should have a care plan for special observations contained with their notes.
- For patients who pose a danger to themselves or others, and any tools or instruments deemed harmful that they may have should be advised that the use of a 'weapon' is unlawful, and ask the patient to hand over the item voluntarily.
  This may warrant searching of the patient and their belongings, but only with the patients permission, and without force. This should be done with consideration given to the legal rights of the patient and conducted in a sensitive manner. Reasons for any suspicion and advice given to the patient should be recorded in the clinical record.
  Any items removed must be witnessed and documented by the nurse and the relatives informed. If the patient refuses to hand over the item and you have positive evidence of a weapon which could be used to harm staff or others, the Police must be called.
- The care plan must state if the patient does not require observation whilst using the toilet or taking bath/shower. A regular summary of the patient's condition, care and treatment must be entered on the special observation care plan. This must include changes in mental state, physical, psychological and social behaviour, pertinent development and significant events. Positive engagement with the service user is essential

- It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place. If there are concerns that the patient is being deprived of their liberty then contact the Adult Safeguarding Lead Nurse (or Duty Manager out-of-hours)

Level 4: Within Arm's Length Therapeutic Observation

This is the highest level of therapeutic observation for patients liable to suicide attempts, harming themselves or being violent/aggressive towards others. They may be at a "high risk" of falls due to confusion or have an unstable physical condition which may have deteriorated and requires constant assessment.

- They should be supervised with close proximity, with due regard for safety, privacy, dignity, gender and environmental dangers. Issues of privacy and dignity, consideration of gender issues and environmental dangers should be discussed and incorporated into their care plan.
  It may be necessary on rare occasions to use more than one member of staff and or Specialist support, for example security. A regular summary of the patient's condition care and treatment must be entered into the Therapeutic Observation care plan. This must include changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events. Positive engagement with the service user is essential. The arrangements for requesting assistance from security is provided in the Standard Operating Procedure – Requesting Security **Presence to assist in the Management of High Risk Violent and Aggressive In-patients (appendix**

- It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place. If there are concerns that the patient is being deprived of their liberty then contact the Adult Safeguarding Lead Nurse

APPENDIX 8

Violent Patient Risk assessment to ascertain level of observation

Level of concern	Level of observation	Who should decide	Who should carry out observation	Level of risk	Review period
To maintain general safety for all in patients unless a higher level indicated	Awareness of whereabouts and wellbeing at all times Minimum standard for all inpatients	Dr and qualified Nurse or MDT; qualified Nurse if no Dr available	Allocated member of nursing staff	**1**	weekly
When there is a risk of self-harm, unpredictability or risks are unclear and frequent contact needs to be maintained. As a step down from a higher level of observation	Intermittent checks on mental state and risk Maximum time interval should be specified and checks varied within this. Should be used on admission and post transfer until assessment has been carried out	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff	**2**	24hrs
Where there is a serious short-term or other significant risk e.g. violence & aggression	Continuous observation within eyesight – this means in the same room or space (i.e. within easy reach)	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff, preferably qualified or in exceptional circumstances security officer	**3**	4hrs
Where there is a serious and imminent risk of suicide or self-harm with impulsivity or a significant risk to others e.g. violence & aggression	Continuous observation within arm's length When more than one person is allocated there must be a lead person doing the observations	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff preferably qualified or in exceptional circumstances security officer	**4**	4hrs

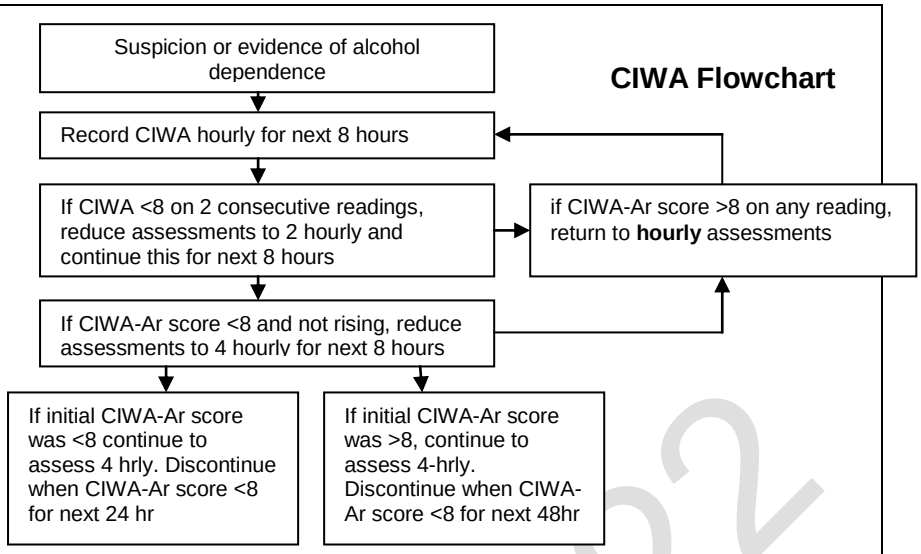
APPENDIX 9

Alcohol Withdrawal Assessment Flowsheet (Based on CIWA-Ar scale)

Patient's Name :	**Unit Number:**											
Assess and rate each of the following (CIWA-Ar Scale)												
Date												
Time												
Nausea / vomiting (0 - 7) 0-none. 1- mild nausea only. 4 - intermittent nausea. 7 - constant nausea, frequent dry heaves & vomiting												
Tremors (0 - 7) 0 – none. 1 – not visible, can be felt. 4 – moderate w/ arms extended. 7– severe, even w/ arms not extended												
Anxiety (0 – 7) 0 – none. 1 – mild anxiety. 4 – moderately anxious. 7 – equivalent to acute panic state												
Agitation (0 – 7) 0 – none. 1 – fairly normal activity. 4 – moderately fidgety / restless. 7 – very agitated / thrashing about												
Paroxysmal Sweats (0 – 7) 0 – none. 1 – barely perceptible sweats, palms moist. 4 – sweat beading forehead. 7 – drenched with sweat.												
Orientation (0 – 4) 0 – orientated. 1 – uncertain about date. 2 – disorientated to date by no more than 2 days. 3 – disorientated to date by > 3 days. 4 – complete disorientation												
Tactile Disturbances (0 – 7) 0 – none. 1 – v. mild itch, P&N, numbness. 2 – mild itch, P&N, burning, numbness. 3 – mod. itch, P&N, burning, numbness. 4 – mod. hallucinations. 5.- severe hallucin-ations. 6 – extremely severe hallucinations. 7 – cont. hallucinations.												
Auditory Disturbances (0 – 7) 0 – none. 1 – v. mild, ability to startle. 2 – mild, ability to startle. 3 – mod. harshness, ability to startle. 4 – mod. hallucinations. 5.- severe hallucinations. 6 – extremely severe hallucinations. 7 – cont. hallucinations.												
Visual Disturbances (0 – 7) 0 – none. 1 – v. mild sensitivity. 2 – mild sensitivity. 3 – mod. sensitivity. 4 – mod. hallucinations. 5.- severe hallucinations. 6 – extremely severe hallucinations. 7 – cont. hallucinations.												
Headache (0 – 7) 0 – none. 1 – v. mild. 2 – mild. 3 – moderate. 4 – mod. severe. 5 – severe. 6 – v. severe. 7 – extremely severe												
Total CIWA-Ar Score												
PRN Med (circle one) **Dose given (mg)**												
Diazepam Lorazepam **Route**												
Time of PRN medication administration												
RN signature / initials												

CIWA	Medication
<10	Nil
10 - 15	5mg diazepam or 0.5mg lorazepam
16 or above	10mg diazepam or 1mg lorazepam

NB:
Prescribe diazepam unless patient is frail elderly, has respiratory failure or severe liver impairment (e.g. INR>2 and Bilirubin >200 or hepatic encephalopathy) in which case use lorazepam.
If requiring > 30mg Diazepam or 3mg Lorazepam in 3 consecutive hours then please inform medical team to review status



Alcohol Withdrawal Assessment Scoring Guidelines
(Clinical Institute Withdrawal Assessment for Alcohol – CIWA-Ar – Scale)

Nausea & Vomiting – Rate on Scale = 0 – 7 0 – None 1 – Mild nausea with no vomiting 2 – 3 – 4 – Intermittent nausea 5 – 6 – 7 – Constant nausea and frequent dry heaves and vomiting	**Tremors** – have patient extend arms and spread fingers. – Rate on Scale = 0 – 7 0 – None 1 – Not visible, but can be felt fingertip to fingertip 2 – 3 – 4 – Moderate, with patient's arms extended 5 – 6 – 7 – Severe, even with arms not extended
Anxiety – Rate on Scale = 0 – 7 0 – No anxiety, patient at ease 1 – Mild anxiety 2 – 3 – 4 – moderately anxious or guarded, so anxiety is inferred 5 – 6 – 7 – Equivalent to acute panic states seen in sever delirium or acute schizophrenic reactions	**Agitation** – Rate on Scale = 0 – 7 0 – Normal activity 1 – somewhat normal activity 2 – 3 – 4 – Moderately fidgety and restless 5 – 6 – 7 – Pacing back and forth, or constantly thrashing about
Paroxysmal Sweats – Rate on Scale = 0 – 7 0 – None 1 – Barely perceptible sweating, palms moist 2 – 3 – 4 – Beads of sweat obvious on forehead 5 – 6 – 7 – Drenching sweats	**Orientation & clouding sensorium** – Ask "What day is this/ Where are you? Who am I?" – Rate on Scale = 0 – 4 0 – Orientated 1 – Cannot perform serial additions or is uncertain about dates 2 – Disorientated to date by no more than 2 calendar days 3 – Disorientated to date by more than 2 calendar days 4 – Disorientated to place and/or person
Tactile Disturbances – Ask "have you experienced any itching, pins and needles sensations, burning or numbness, or a feeling of bugs crawling on or under your skin?" – Rate on Scale = 0 – 7 0 – None 1 – Very mild itching, pins & needles, burning or numbness 2 – Mild itching, pins & needles, burning or numbness 3 – Moderate itching, pins & needles, burning or numbness 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 – Continuous hallucinations	**Auditory Disturbances** – Ask "Are you aware of sounds around you? Are they harsh or startling? Do you hear anything that disturbs you or that you know isn't there?" – Rate on Scale = 0 – 7 0 – None 1 – Very mild harshness or ability to startle 2 – Mild harshness or ability to startle 3 – Moderate Harshness or ability to startle 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 – Continuous hallucinations
Visual Disturbances – Ask "Does the light appear to be too bright? Is its colour different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?" – Rate on Scale = 0 – 7 0 – None 1 – Very mild sensitivity 2 – Mild sensitivity 3 – Moderate sensitivity 4 – Moderate hallucinations 5 – Severe hallucinations 6 – Extremely severe hallucinations 7 – Continuous hallucinations	**Headache** – Ask "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or light-headedness – Rate on Scale = 0 – 7 0 – Not present 1 – Very mild 2 – Mild 3 – Moderate 4 – Moderately severe 5 – Severe 6 – Very Severe 7 – Extremely severe

Procedure

1. Assess and rate each of the 10 criteria of the CIWA-Ar scale. Each criterion is rated on a scale from 0 – 7, except for "Orientation and clouding of sensorium" which is rated on a scale of 0 – 4. Add up the scores for all 10 criteria. This is then the total CIWA-Ar score for the patient at the time of the assessment. Prophylactic medication should be commenced on any patient with a total CIWA-Ar score of ≥10 (i.e. commence withdrawal medication in accordance with medical guidelines).
2. Document NEWS and CIWA-Ar assessment. Document administration of PRN medications on the assessment sheet as well as the drug chart.

3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of ≥10 provides the best means to prevent the progression of withdrawal
4. In the patient who has chronic liver disease and presents with increasing drowsiness **+/-** agitation, may be an indication of encephalopathy – in such cases an experienced clinician will need to assess

Appendix 10

Staff Support Counselling Service

Longton Cottage Hospital

To contact us:

For further information or to make a confidential self-referral please contact:

Staff Support Counselling Services

Longton Cottage Hospital

Upper Belgrave Road

Longton

STOKE-ON-TRENT

Staffs ST3 4QX

[redacted]

When you make contact with the service you will be advised of all locations that you can access for counselling some of which are included below. The service recognises that NHS staff do not work a traditional 9.00 am – 5.00 pm Monday to Friday week so the service offers evening sessions as well as Saturday mornings. You can also choose to be seen by a male or female counsellor if that is an important choice for you.

Locations:
Royal Stoke University Hospital
County Hospital Stafford
Haywood Hospital
Longton Cottage Hospital
Harplands Hospital
In addition there are satellite locations in the following areas:
Stafford
Hednesford
Norton Cannes
Barton/Burton Upon Trent
Newcastle Staffordshire
Tamworth