

British Society of Paediatric Dentistry: a policy document on the use of Clinical Holding in the dental care of children

These clinical guidelines have been developed in order to provide information and guidance on the use of Clinical Holding in Paediatric Dentistry. They provide a framework for best practice by the inclusion of recommendations regarding appropriate protocols, training, risk assessment procedures, record keeping and reflection on practice. At all times, the *best interests* of the child are paramount.

This document was originally published in 2008 and included a substantial section on Consent. The latest guidelines no longer include a separate section on Consent as clinicians are advised to follow national guidance for obtaining informed consent, to include if anticipated, the use of Clinical Holding.

INTRODUCTION

Definitions of Clinical Holding

‘The use of physical holds (clinical holding), to assist or support a patient to receive clinical dental care or treatment in situations where their behaviour may limit the ability of the dental team to effectively deliver treatment, or where the patient’s behaviour may present a safety risk to themselves, members of the dental team or other accompanying persons.’ i

Terminology

“Clinical Holding and Physical Intervention” (PI) are terminologies currently being used. For the purpose of this document, the description “Clinical Holding in Dentistry” (CH-D) will be the terminology of choice, unless directly including specific reference to Physical Intervention.

Is there ever justification for Clinical Holding?

Ideally, all dental care for children should be provided under local anaesthesia using routine behaviour management techniques, such as “Tell-show-do” to achieve a satisfactory outcome. However, there will always be children who do not respond to this approach e.g. pre co-operative child; and those with challenging behaviours who may or may not have an accompanying disability. It also includes those children who present for emergency care where pain, fear and shock override the child’s normal coping mechanisms.

Within the UK, the majority of dentists working in this field would consider alternative approaches to this management issue, for example, some form of conscious sedation. In some cultures, the use of Clinical Holding, such as holding or even physically containing the child is deemed to be

acceptable. The Scottish Intercollegiate Guideline Network document on safe sedation of children undergoing diagnostic and therapeutic procedures, states that *‘there is no place for physical restraint or hand over mouth (HOM) techniques in the dental treatment of children’*.ⁱ

However, there is a dilemma facing clinicians in the management of an un-cooperative (struggling) child who needs to be supported in some way, if a necessary operative intervention is to be safely and effectively administered.

All those charged with the care of a child have a ‘duty of care’ to that child, to promote their wellbeing, in addition to protecting and supporting their rights and best interests. These roles need to be discharged within the legal framework of the jurisdiction in which the professional is working.

Ethics in clinical holding

As part of the decision making and risk assessment process, the ethics and legal framework should be considered.

According to the principles of biomedical ethics, health professionals should:

- **Non maleficence - first do no harm**
- **Act in the patients best interests**
- **Respect the patient’s right to refuse**

Balancing the last point with the other principles can pose a dilemma but it can be used in the decision making process by asking;

- Is what you are proposing really in the patient’s best interests?
- Is the patient happy to go ahead?
- If not, is there an alternative?
- If there is no alternative, what will be the outcome if you do not proceed with treatment?

(See Clinical Holding Flow Chart)

In many cases, not proceeding with treatment at that moment in time will have no immediate adverse outcome for the patient and treatment may be able to proceed with more success at a later date. In most instances, paediatric dentists do not have to routinely deal with cases where the patient will die if they do not have their dental procedure undertaken.

However, there are cases where the patient will suffer undue pain and distress if treatment is not provided as planned. So the clinician may feel that they have very little choice but to seek to proceed with treatment, despite the patient’s wishes.

Once the ethical issues have been considered for the patient, the clinician should now seek valid consent for the treatment proposed.

“The inappropriate use of restrictive physical intervention may give rise to criminal charges, action under civil law or prosecution under health and safety legislation. As a general rule, restrictive physical interventions should only be used when other strategies (which do not employ force) have been tried and found to be unsuccessful or, in an emergency, when the risks of not employing a restrictive intervention are outweighed by the risks of using force”.ⁱ

PRINCIPLES

- Wherever possible, Clinical Holding should be used in a way that is sensitive to and respects the cultural expectation of children and parents/carers, and their attitudes towards physical contact
- All Clinical Holding should be used to achieve outcomes that reflect the best interests of the child and their dental care
- All planned Clinical Holding strategies should be one component of a broader approach to behaviour management and

the use of other appropriate techniques to enable delivery of dental care e.g. Inhalation Sedation The use of CH-D should represent a last resort where all other non-physical methods have been considered, used and found to be ineffective ^{xiv,ii,iii,iv}

- The use of CH-D should be subject to risk assessment in order to ensure that a consideration can be made as to the level of risk such strategies may pose to the individual patients on the dental team
- CH-D should only be used to manage the risk associated with a patient's behaviour and not to force compliance with treatment ^{v,xvi}
- Planned Clinical Holding strategies should be discussed and agreed in advance with formal written consent.
- Information should be shared on which techniques may be utilised, including why they may be needed, and how they have been implemented
- Good practice will involve consultation, effective communication and active collaboration and there must be sufficient time for questions, with all stakeholders involved

It is helpful to distinguish between planned Clinical Holding and the use of emergency or unplanned Clinical Holding, which occurs in response to unforeseen events. The latter should only be employed to achieve one of the following outcomes:

- To break away or disengage from dangerous or harmful contact initiated by the service user.
- To protect a patient from a dangerous situation e.g. contact with a dental instrument or equipment

In recent years, statutory guidance relating to the use of "*restrictive physical interventions*" has been issued to provide a clear framework

and a set of guiding principles. Whilst not specifically aimed at the use of Clinical holding in Dentistry (CH-D), or patients who require special care dental intervention, such guidance is aimed at those vulnerable individuals (children and adults) who sometimes present to dental services.

Everyone has a right to be safe. This includes the patient receiving treatment as well as those members of the dental team working with them. In situations where a patient's behaviour poses a risk to themselves or others, or in situations where a patient assaults a member of the dental team, the emergency use of CH-D may be justified to prevent or minimise harm. However, within the professional and legal frameworks the use of CH-D must be proportional to the amount of harm or risk presented i.e. the least amount of force is used for the minimum amount of time. ^{vi}

Child factors

In this context, 'Clinical Holding' needs to be applied with:

- Due consideration for the rights of the child, in particular, the actual necessity to accomplish the procedure. This is important when a potential emergency situation precludes consideration of other approaches
- The minimum necessary intervention to accomplish a procedure, whilst aiming for a minimum level, if any, of psychological distress to the patient ^{vii}
- Full preparation of the child and parent/guardian but cognisant of the fact that a parent/guardian may not wish to be present and respecting that right
- Consideration of the legal framework and the necessity to involve the courts where applicable

Staff factors

Consideration needs to be given to:

- Pre-empting the need for Clinical Holding by exploring alternative forms of pain and behaviour management, such as conscious sedation. This concept is also highlighted in the *Welsh Assembly Government 2005: Framework for restrictive physical intervention policy in practice*, where it mentions preventing the necessity for “physical intervention” through the development of preventative strategies^{viii}
- Selecting a mechanism that is appropriate for the age of the child and intervention planned, building in distraction as part of the technique^{xii}
- Obtaining consent, where possible from the child or if not, the parent/guardian’s permission and the child’s agreement
- Having an agreement in place so that other staff can be part of the decision making, especially if they disagree with the decision made Supporting the whole family through the entire process
- Supporting the whole family through the entire process
- Enabling all staff, carers, parents and, if appropriate, the patient themselves; to be given the opportunity to ‘debrief’ afterwards
- Using the correct documentation and auditing the processes of CH-D

Given that this is a major infringement of an individual’s right to liberty, it is important that the rules governing such an intervention are clearly understood by those working in this area.

Training, review and audit

All members of staff who are required to employ CH-D will need specialised training, both foundation and annual updates, and

should only employ methods for which they have received specific training which is nationally accredited.^{ix,x}

Trainers should be carefully selected with reference to the BILD Code of Practice and evidence of professional accreditation.^{vii,xi}

Training should be updated regularly to ensure that all members of staff are kept apprised of any changes and key issues which affect and influence Clinical Holding decisions.

Organisational factors

A clear organisational policy framework should be developed, approved and implemented in order to protect vulnerable patients from the misuse or abuse of CH-D, and practitioners from undue levels of professional or physical risk (e.g. litigation or trauma). Any emergency use of CH-D must be accounted for within the organisational policy framework.^{xii,xiii,xiv}

Procedures and Policies

All departments who are likely to employ CH-D techniques, must have a policy in place.^{xv} Policies are expected to include reference to the following: i^{vii,xi}:

- Recommendations for when CH-D should and should not be used
- A description of behaviours which may require CH-D
- Who to notify
- Time limits
- Staff must be involved in the formulation of protocols and receive appropriate training which should be documented, audited and regularly reappraised
- Strategies for preventing the occurrence of behaviours which precipitate the use of CH-D

- Strategies for ‘de-escalation’ or ‘diffusion’ which can avert the need for CH-D/PI
- Procedures for post incident support and reporting and de-briefing for staff, children, service users and their families
- Mechanisms in place for staff to be heard if they disagree with a decision (Royal College of Nursing).^{xvi}

Having an appropriate policy in place, as part of the induction process to all relevant staff, including the anaesthetic team^{xvi}

The concept of reasonable force where ‘*reasonableness*’ is determined with reference to all the circumstances, including:

- The seriousness of the incident, the relative risks arising from using a CH-D compared with using other strategies
- The age, cultural background, gender stature and medical history of the child or service user concerned
- The application of gradually increasing or decreasing levels of CH-D in response to the person’s behaviour
- Risk management and risk assessment
- Information on ‘planned’ and ‘emergency’ CH-D
- Emphasis on the importance of safety to staff and patients/service users
- Procedures for obtaining an Independent advocate, discussing CH-D issues and how to proceed within the legal framework of obtaining an opinion from a panel

Record Keeping

Clinical patient notes should contain:

- Reference to the local protocol
- A record of the views of those with parental responsibility, or next of kin family members, in relation to CH-D, including IMCA approval if relevant

- **Previous methods of behavioural management** used and their effectiveness

- **Previous CH-D techniques employed**, their effectiveness, why it was necessary, who was involved, where it occurred, detail on the method/techniques used, and for how long the intervention occurred^{xi}

CH-D should be part of an individual treatment plan which has ordinarily been agreed by the patient^{xviiixviii} and the use for CH-D should be recorded along with any injuries that may arise from such use.^x

Clinical Holding - SUMMARY

All professionals and families have a duty of care to those for whom they have a responsibility and are required to act in the child’s best interests. It also extends to corporate responsibilities for health and safety requirements which concerns the safety of staff involved in Clinical Holding.^{xvi}

Clinical Holding should only be used as a management technique when there is a clear need to undertake a procedure for the child.

Alternative approaches must always have been considered and, if clinically feasible, time set aside to explore these options further.

The intervention must always be of the minimum necessary to accomplish the task, only likely to cause minimal or no psychological distress and never for the convenience of the professional. A debriefing should take place with the child and family after the procedure.

Any, such intervention must have the parents' permission and if possible, the child's assent, unless the child is competent to consent, which should be recorded in the clinical notes along with the nature of the intervention and its justification.

No one should undertake any form of Clinical Holding without the appropriate training in place.

References

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- ^v Department of Constitutional affairs. Making decisions about your health, welfare and finances. Who decides if you can't. 2007 ;HMSO, London.
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Clinical Holding Flowchart

