British Society for Disability and Oral Health

Unlocking Barriers to Care

Guidelines for

'Clinical Holding' Skills for Dental Services

for people unable to comply with routine oral health care

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These guidelines have been updated and developed with support and contributions from Selina Master, Karen Gordon, Ken Dalley, Michelle Golding, June Nunn, Janet Richardson, Sue Greening and Kathy Wilson and are an adjunct to:

BRITISH SOCIETY FOR DISABILITY AND ORAL HEALTH original Policy Document:

PRINCIPLES ON INTERVENTION FOR PEOPLE UNABLE TO COMPLY WITH ROUTINE DENTAL CARE [1]

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This revised edition endeavours to take account of further developments in the field and to build on the existing framework of good practice in relation to physical interventions and the range of non physical preventative measures that exist in order to deliver safe and effective treatment to patients.

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Introduction

The use of restrictive physical interventions within services for people with learning disabilities and mental ill health is widely accepted as a possible appropriate response to incidents of severe challenging behaviour, aggression and/or violence. Since 1996, the British Institute of Learning Disabilities [2, 3, 4, 5] (BILD), and the Department of Health (DH) and the Department for Education and Skills (DfES) [6, 7, 8] have worked together across governments in all four U.K countries [9, 10, 11] to improve standards in relation to this specific area of practice for children and adults who may be subject to such approaches.

Within the area of general dental practice, and more specifically special care dentistry, there are some situations where the use of physical interventions may be appropriate. However, current national guidance tends to focus on the management of challenging behaviour within specific populations and this presents difficulties in interpretation for dental practitioners developing a professional framework which supports the use of physical interventions within the context of dental treatment. As a result, some patients may not receive appropriate, safe or effective dental treatment for reasons not necessarily related to challenging behaviour, but because their behaviour presents a risk to themselves, to the dental team or accompanying persons.

Whilst certain patient populations have traditionally required specialist dental services as a result of the risks that arise from their behaviour (e.g., children, young people and adults with learning disabilities), there are many other patient groups that present clinical staff with compromises or difficulties during assessment and treatment. Consequently, these guidelines have been developed to help clinicians make appropriate decisions relating to the assessment and treatment outcomes for those patients who may require some form of physical support or intervention as part of their treatment plan, regardless of cause.

1. Definitions

Although the DH and DfES Joint Guidance [5] broadly defines physical intervention as the *'use of force to control a person's behaviour'*, and the Mental Capacity Act, 2005, Section 6(4) [12] states that someone is using restraint if they *'use force - or threaten to use force - to make someone do something that they are resisting, or restrict another person's freedom of movement, whether they are resisting or not'*, more recent definitions have attempted to clarify the methods of restriction that might be used [13].

Within special care dental practice, it may be necessary in some circumstances to use physical holds in order to provide safe and appropriate oral health care. These clinical guidelines are provided in relation to the use of Specialist Clinical Holding Skills for Dental Services (*clinical holding*) and therefore use the following definition to reflect the specific context related to dental examination, treatment or oral health care:

'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'

2. Summary Statement

These guidelines provide a clear and consistent professional framework relating to the use of clinical holding within dental services. The use of clinical holding should not be designed or used to enforce oral health care assessment and/or treatment and are intended to supplement and support the existing practices and strategies used by dental

practitioners to deliver safe and effective treatment. Importantly, these guidelines are founded upon and are congruent with current standards of professional practice in dentistry:

- the impact of oral ill-health on the patient's quality of life can be profound. Good oral health has positive benefits for health, dignity, self esteem, social integration and general nutrition [14, 15, 16];
- healthcare professionals providing dental care and treatment share common values and a commitment to working within the law, adherence of accepted clinical and professional standards and above all, operating within the best interests of the service user [14, 15];
- everyone has a right to equal access and equal standards of health and care [16, 17];
- everyone has a right to autonomy in relation to decisions about their healthcare, or have the right to have as much help as possible to make such decisions [16, 17];
- any treatment should only be carried out with due consideration to the patient's best interests and represent the least restrictive and detrimental option [11, 18, 19, 20, 21, 26];
- everyone has a right to be safe [22, 23]; and
- practitioners should work in a manner that promotes the long term well-being and interests of patients in order to address health inequalities of some patient groups and to deliver improved health outcomes [18, 19, 24].

The principles outlined must be communicated to all members of the multi-professional team managing and delivering the patient's treatment, as well as patient's relatives and advocates, in order to support a positive and proactive approach to oral health care rather than merely authorising ways of managing difficult patient behaviour. Clinical holding should be used as infrequently as possible and used in the best interest of the patient in order to deliver appropriate treatment outcomes whilst at the same time ensuring that the patient's sense of dignity is fully maintained.

3. Context and Rationale

The context for this guidance relates to those situations where a clinical team has determined that a patient's assessment or course of treatment cannot be carried out effectively and/or safely as a result of the behaviour presented by the patient. Whilst it is acknowledged that in real-life situations there are numerous factors that may influence the patient's behaviour and the level of risk such behaviour may present during oral examination or treatment, it is the professional responsibility of the Dentist, Dental staff, or other staff members involved in undertaking the treatment to consider their own general conduct and give due diligence to any decision to initiate, continue or cease using clinical holding. In general, such behaviour or risk is uncommon but may typically arise in patients who lack capacity or may be unable to comply due to their personal characteristics. For example, clinical holding may be appropriate when treating:

- some patients with learning disabilities and/or autistic spectrum disorder;
- some patients with dementia;
- some patients with mental ill health;
- some patients with degenerative conditions, (e.g., Huntington's disease or Multiple Sclerosis) ;
- some patients with involuntary movements or an inability to control their movement, (e.g. Cerebral Palsy, Parkinson's disease) ;
- some severely anxious patients;
- some patients who lack capacity and lack the ability to understand and cooperate with a specific clinical intervention or treatment; and
- some patients with specific medical conditions, (e.g., CVA, brain tumour, acquired brain injury).

The issue of concern relating to patients who are unable to comply with routine treatment is more often about the safe delivery, rather than the appropriateness of the specific oral health care required. Clearly, practitioners have

a duty of care to ensure that identified care and treatment is provided in an effective and safe way. In this respect, the decision to use clinical holding must be considered alongside a range of other issues and consequently, in order to meet the current standards of professional practice, the use of non-physical and non-intrusive strategies must remain the preferred approach to support treatment. Therefore, when considering the use of clinical holding, a number of factors must be addressed through the patient's treatment plan including:

- there will be known triggers for behaviour change in some patients which will help practitioners to make decisions which specifically relate to each patient at the time the treatment is carried out;
- the timing of appointments, medication and other aspects of daily routine may be crucial in delivering effective treatment outcomes for some patients;
- the use of augmentative techniques (such as relaxation techniques, music therapy, embedded commands etc) may be beneficial with some patients in gaining improved cooperation;
- acclimatisation, behaviour modification and consistency may improve compliance for some patients and therefore remove the need for clinical holding; and
- compliance from the patient may not be consistent or predictable and may vary with different procedures on different days or with different carers or professionals present. A particular approach to treatment today may not be an appropriate approach with regard to the next course of treatment the patient requires.
- appropriate communication strategies to maximise opportunities for care

Notwithstanding the above, there may be occasions where typical strategies for some patients have failed or are not appropriate and the use of clinical holding may be considered acceptable in order to ensure the patient receives appropriate or necessary treatment. In terms of the application to practice, clinical holding should only take place in the following circumstances:

(a) Where a patient explicitly consents

A patient with capacity may require physical assistance or support, or may behave in a manner that presents a safety risk to self or others (e.g. an anxious patient who repeatedly brings his/her hands up to their mouth or attempts to hold the practitioners hands). In such circumstances, clinical holding may be appropriate to support the patient during the course of treatment. Clearly, the procedure must have been discussed with the patient prior to treatment taking place and the patient must have provided informed consent [25]. Importantly in such scenarios, the patient can withdraw consent at any time and the use of clinical holding should be terminated immediately.

(b) Where a patient lacks capacity to consent

A patient without capacity may require physical assistance or support, or may behave in a manner that presents a safety risk to self or others (e.g., a patient with profound learning disabilities who attempts to bite during an oral examination). In accordance with the Mental Capacity Act; the Adults with Incapacity (Scotland) Act; and accepted professional practice [11, 25, 26, 27, 28, 29, 30], a patient without capacity may require personal care, healthcare or treatment which is in their best interests (e.g. a patient with dementia has a suspected oral tumour but will not allow any attempts to conduct an oral examination). In such circumstances clinical holding may be agreed as an appropriate part of the treatment plan to deliver dental care by dental staff provided that it is agreed in accordance with the Mental Capacity Act Code of Practice and represents the least restrictive and detrimental course of action.

(c) Unplanned emergencies, where any patient presents significant risk

It may be reasonable under common law to use clinical holding with any patient (with or without capacity) as an emergency response to any situation where their behaviour represents an immediate or significant risk to

themselves or others (e.g. a patient who during the course of treatment strikes out at dental team or other accompanying persons)

4. Legal and Professional Context

All patients have a right to access dental services and have a right to legal protection, particularly in relation to the abuse or misuse of restrictive interventions [21, 22, 23]. Consequently, the dental team involved in undertaking the treatment using clinical holding must ensure that their practice remains within accepted legal and professional standards. Although the Joint Guidance [5] provides a broad context for the use of physical interventions, there is a need to ensure that dental team that use clinical holding do so within a context that reflects their specific practice speciality. Whilst it is not the intention of this policy to provide a full outline of the legal and professional issues which relate to the wider use of restrictive physical interventions within the U.K, the specific points detailed below are intended to provide practitioners with a legal and professional framework in relation to clinical holding and special care dentistry. Specific factors which should be considered when deciding to use clinical holding as part a patient's treatment include:

- Duty of Care
- Best Interests or Acts of Necessity
- Informed Consent
- Mental Capacity
- Statutory Guidance
- The Right to be Safe

(a) Duty of Care

Duty of care [31] requires practitioners to take reasonable care to avoid acts or omissions that are likely to cause harm to another person. Clearly, the use of clinical holding as part of a patient's dental plan is subject to this responsibility, particularly since it is argued that a failure to provide individuals with the necessary support, care or treatment they require constitutes neglect or acts of omission.
Although the term *reasonable care* is not specifically defined, judgements about whether or not the use of clinical holding can be justified must consider a range of factors as to whether the action is:

- appropriate to the patient and their circumstances;
- the least restrictive option;
- in the patient's best interests;
- considered to be less of a risk to the patient than not undertaking the course of action; and
- agreed by the patient, or where the patient lacks capacity, agreed as the right course of action by the clinical team in consultation with the person's primary carer.

(b) Best Interests or Acts of Necessity

The law provides justification for any action that is taken as a result of necessity to prevent serious harm provided that the course of action was reasonable and represented less harm to the person than would have occurred should no action have been taken. Justification could be argued on the basis that the intervention was made either to manage the risk associated with the patient's behaviour, or to ensure treatment was carried out in the person's 'best interests'. Decisions made on behalf of people without capacity should be made in their best interests and the following factors considered when making an assessment:

- the ascertainable wishes and feelings (past and present) of the patient;

- the need to support and encourage the patient to participate as fully as possible in any decision or action affecting him or her;
- the views of other people whom it is appropriate and practical to consult with about the patient's wishes and feelings and what would be in his or her best interests; and
- whether the outcome(s) of the proposed treatment can be satisfactorily achieved using less restrictive practices.

With regard to children and young people, the Children Act [32] and Children (Scotland) Act [33] makes the interests of any child the paramount concern and in addition to the above assessment considerations, a number of other factors are relevant e.g. the child's age and level of understanding; any harm that might occur (now or in the future) as a result of the delivery of treatment or failure to do so; the capability of the parent/carer to support the treatment plan to its conclusion. The Court of Appeal has clarified that any decision to use specific interventions or treatment lies with the medical or dental professional and constitutes 'best interests' when:

> *'It follows from the decision that a patient is not competent to refuse treatment that such treatment may have to be given against her continued objection if it is in her best interests that the treatment be given, despite those objections. The extent of force or compulsion, which may become necessary, can only be judged in each individual case and by the health professional. It may become for them a balance between continuing treatment, which is forcibly opposed, and deciding not to continue with it. A clinical decision.'* (cited Bridgman and Wilson, 2000 [33])

Taking this point into account, whilst a legal and professional framework can guide practitioners in their broader understanding of the issues and factors for consideration, any decision to use clinical holding (whether planned, or for emergency use) will ultimately be a clinical one based upon the presenting situation at the time as assessed by the treating practitioner(s).

(c) Informed Consent

The principle of gaining informed consent from all patients (or in the case of children, their parents) prior to treatment is a fundamental part of medical practice [34] and ensures that practitioners do not act in a manner which may be considered unprofessional or unlawful. A patient's ability to give informed consent is based upon their capacity to understand the benefits and risks associated with the proposed treatment and thus, make a decision as to whether or not they wish to proceed. The principle of informed consent is important as it ensures that:

- the patient is provided with the necessary information about the proposed treatment
- the patient understands the information provided
- the decision is made by the patient (or in the case of children, their parents) and accounts for their wishes
- treatment is only provided in accordance with the patient's wishes, even if the patient's decision is viewed by practitioners as contrary to their best interests

Within dental practice, a patient is considered to have given informed consent when they sit in the dental chair and begin to co-operate with the necessary examination and/or procedure. As such, there is often a degree to which informed consent is assumed by the dental team, based upon their observation, knowledge and experience of the patient [27], or inferred by the patient through their compliance. Importantly, informed consent is only valid as long as the patient's consent continues i.e. at any time during the treatment the patient retains the right to withdraw such consent. Consequently, it is good practice to gain informed consent (verbal, nonverbal or written) for all irreversible treatments as well as sedation or general anaesthesia once the patient has been provided with all the information about the treatment and they have had time to consider their decision [35, 36].

In such circumstances, the validity of consent is not dependant on the form in which it is given. Whilst it is common practice to ask the patient to sign a consent form, a signature on a consent form does not in itself prove the consent is valid since the purpose of the form is to demonstrate that a discussion has taken place [36, 37, 38]. In circumstances where a patient cannot sign a form or may lack capacity (see below), a protocol should require that the discussion is clearly documented in the patient's notes, including the names of any witnesses accompanying the patient.

(d) Mental Capacity Legislation

The principle of informed consent is guided by the assumption that individual patients have the capacity to provide such consent, or in the case of children, capacity can be gained by proxy from a legal parent or guardian. However, where there are doubts about an adult's ability to provide consent, recent legislation and guidance [11, 12, 25, 27, 29, 30] sets out a framework that guides practitioners in relation to making decisions on behalf of adults who lack capacity. Dental practitioners are expected to work in accordance with the prevailing legislation to ensure that their decision-making promotes and protects the rights of vulnerable patients who may not be considered to have the capacity to make informed judgements in some circumstances. In addition, any assessment of capacity must consider whether the patient can understand the information; whether they are able to retain the information; whether they are able to use or assess the information to make their decision;
and whether they are able to communicate their decision. In this respect, the following key points are crucial to treatment decisions and treatment plans relating to a patient without capacity:

- patients who lack capacity remain the focus of any decisions made, or action taken, on their behalf;
- an individual approach is taken which centres around the best interests of the patient and not the views or convenience of those who offer support;
- vulnerable patients are protected and involved in as many decisions as possible;
- patients must be assumed to have capacity unless it is established that they do not;
- a patient is not considered as being unable to make an informed decision unless all practicable steps to help them to do so have been taken without success;
- a patient is not considered unable to make informed decisions merely because their decisions are unwise; and
- when taking action or reaching a decision, the least restrictive intervention must be made to minimise the impact on the patient's rights and freedom of choice.

In order to comply with legislation, the starting point for decision making must be from the perspective that the patient has capacity and therefore, should provide informal or formal consent for the use of clinical holding in order to enable any treatment to be carried out. For a patient to be considered as lacking capacity [11], evidence must be provided and recorded to establish that:

- the patient has an impairment of, or disturbance in, the functioning of the brain; and
- the impairment or disturbance in functioning is sufficient that the person lacks the ability to make a particular decision at the time it needs to be made.

In Scotland, where an individual is judged to lack capacity to consent, a Certificate of Incapacity should be completed if appropriate and an agreed care plan developed. Consequently, if a dental practitioner provides any clinical assessment or treatment that involves the use of clinical holding for a person who lacks capacity, a 'lawful excuse' or 'authority to treat' for providing the treatment in the absence of the patient's informed consent exists within the legislation (under the Adults with Incapacity (Scotland) Act, the authority to treat requires the issuing of a certificate of incapacity unless the urgency of the situation makes this impossible) provided that:

- it is established that the patient lacks capacity;

- it is done in the patient's best interests and protects them from harm;
- it is reasonable and proportionate to the likelihood of the patient causing harm to themselves or others; and
- it is the least restrictive response.

Whilst dental practitioners take the ultimate responsibility for the use of clinical holding as part of the planned process of treatment, the patient should always be fully involved and provide informed consent. In situations where a patient is unable to consent, decisions must comply with good practice (see table1) and is likely to be taken as part of multidisciplinary team 'best interests' discussion. Subsequently, the benefits of delivering effective treatment must outweigh the risks and only be considered when all other treatment options have been explored and failed or are deemed inappropriate. Where there is a dispute as to the relevance or appropriateness of planned use of clinical holding, an appropriate person (e.g. Independent Mental Capacity Advocate or in Scotland an

appointed Welfare Guardian) may be used to represent the patient and inform the decision as to whether or not intervention should take place. In situations where clinical holding is used as an emergency response to an unforeseen risk arising from the patient's behaviour, the principle of 'everyone has the right to be safe' is relevant and therefore will require dental practitioners to make professional judgements.

Table 1: Good practice approach in determining 'best interest' decisions for patients who lack capacity

Treat the patient as an individual and with respect

- Establish the patient's past and present wishes and feelings.
- Consider how the patient may make a decision if they were acting for themselves.
- Consider how the patient's beliefs and values (e.g. religious, cultural, moral, social) would be likely to shape their preferences.
- Do not make assumption about the patient's best interests on the basis of their appearance, behaviour, lifestyle, age or condition.
- Avoid discrimination by implementing a proactive anti-discriminatory approach.

Encourage the full participation and involvement of the patient

- Provide as much information as is possible to the patient (in a format they can understand).
- Involve them in the discussions and decision-making process for their oral health care treatment plan.

Identify and discuss all the relevant circumstances relating to the treatment.

- Establish the different issues that impact on the decision.
- Identify the treatment options and outline the benefits and risks associated with each.
- Highlight the risks and benefits associated with no treatment.

Avoid the unnecessary or unreasonable restriction of the patients rights

- Remember to look toward the least restrictive option when deciding upon the agreed course of action.

Consider if this decision can be postponed to a point in the future when the patient may be able to consent

- Consider whether or not the person may regain or have improved capacity at some point in the future and defer decisions if appropriate

Consult others

- Establish who else may help with the decision including anyone who is significant in the person's life (e.g., relative, paid carers, friends).
- Engage the help of an Independent Mental Capacity Advocate or an appointed Welfare Guardian (Scotland) where the patient has no

one to help with the decision, and the decision affects a major aspect if their life.

Take everything into account

- Gather information from all perspectives and form a judgement which balances the benefits and risks to the patient

(e) Statutory Guidance

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, 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. Consequently, the use of any physical strategies should be commensurate with such guidance (in both planned and unplanned situations) and requires dental practitioners to make defensible decisions that are based upon the following principles:

- a clear organisational policy framework has been implemented in order to protect vulnerable patients from the misuse or abuse of clinical holding, and practitioners from undue levels of professional or physical risk (e.g. litigation or trauma). Any emergency use of clinical holding must be accounted for within the organisational policy framework [2, 3, 4, 5];
- the existence of organisational approval and guidance for the use of clinical holding i.e. an organisational risk assessment and authorisation of the specific interventions that practitioners are authorised and expected to use in certain circumstances [2, 3, 4];
- the use of clinical holding 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 and the dental team [2];
- those Dental practitioners who may be required to use clinical holding should receive training (both basic and update training) which is nationally accredited [5, 6];
- the use of clinical holding should represent a last resort where all other non-physical methods have been considered, used and found to be ineffective [2, 3, 8, 9, 12];
- clinical holding should always be used alongside, and in conjunction with, other non-physical approaches;
- the least restrictive method(s) should be used [2, 4];
- clinical holding should only be used to manage the risks associated with a patient's behaviour and not to force compliance with treatment [20, 21];
- clinical holding should be part of an individual treatment plan which has ordinarily been agreed by the patient [26, 28]; and
- the use of clinical holding should be recorded along with any injuries that may arise from such use [5];

(f) The right to be safe

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 clinical holding may be justified to prevent or minimise harm. However, within the professional and legal frameworks, interventions 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.

5. Risks

The delivery of oral care and treatment is not without risk to the patient. Many factors may contribute to the level of risk (e.g. the nature of the procedure) and might be exacerbated by the individual profile of the patient, particularly those patients with poor health profiles and/or existing medical conditions. It is not unusual for some patients who present in special care dentistry to have some pre-existing co-morbid condition(s) which may impact on the level of risk associated with the use of clinical holding e.g. epilepsy, obesity, heart conditions. Whilst there have been some reported restraint-related deaths within the U.K. [34], these do not reflect the context in which clinical holding
skills are taught or expected to be used. Nevertheless, it is important that all members of the dental team are aware of the general risks associated with the use of any physical holding skills and that such interventions are implemented in a manner that safeguards the patient and minimises risk. In the main, the greatest risks in relation to physical holding techniques arise from:

- Soft tissue injury (skin, muscles, ligaments, tendons)
- Articular or bony injury (joint and bones)
- Respiratory restriction (this includes all 3 aspects of the respiratory function: airway, intercostals activity, and gaseous exchange).
- Cardiovascular restriction (including the heart and the peripheral vascular system)
- Psychological distress

Given that any physical holding technique can present a degree of risk, it is important that any use of intervention takes account of the level of risk for each individual patient, on each occasions of use. This individualised method is important in order to ensure that individual risk factors for each patient are unaccounted for, and to reduce the likelihood of clinical holding becoming custom and practice. Importantly, once the decision is reached to use clinical holding in a planned way (or in an emergency) practitioners must continually monitor and assess the efficacy and presenting risks associated with the procedure. If at any time, the patient becomes distressed, withdraws their consent, or there is concern expressed by staff, the intervention should be discontinued. Although non-exhaustive, table 2 outlines factors which should result in a discontinuation of clinical holding.

Table 2: Reasons to discontinue clinical holding

• When the patient withdraws consent unless: (a) they lack capacity and the decision to use clinical holding has been agreed; or (b) the situation is an emergency and it is necessary to safeguard the patient or others from serious harm;
• When the patient shows signs of extreme psychological distress/anxiety;
• When the patient indicates (verbally or non-verbally) that a particular hold is causing pain or discomfort;
• When the patient shows signs of respiratory compromise;
• When the patient shows signs of circulatory compromise;
• When the patient vomits;
• When the patient has a seizure or convulsion;

6. Training

The effectiveness of any policy or guidance on the use of restrictive physical interventions is dependent upon the knowledge and skill of practitioners to apply the agreed interventions within a practice framework. Successful implementation of the organisational policy guidance is therefore, reliant on ensuring that key personnel receive appropriate training that is 'fit for purpose'. This guidance cannot determine the specific interventions that might

be appropriate for each dental service because this detail remains the responsibility of each provider service and should be determined within their own commissioning process.

The British Institute of Learning Disabilities (BILD) currently manage a national Physical Intervention Accreditation Scheme (PIAS) that can be used as a benchmark by organisations wishing to commission training to identify suitable training providers. However, accreditation alone should not determine a particular choice of training provider i.e. the commissioning organisation must establish that the training provider has a suitable professional background, qualifications and experience appropriate to special care dentistry, and that the proposed training programme (and the specific physical skills contained within) is suitable for use in relation to the patient population and the range of treatments available.

Significantly, an organisation is required to account for the use of any physical interventions within its services and therefore, the commissioning organisation must take responsibility for identifying and authorising the range of options available to staff. In this respect, all training commissioned should be reviewed and agreed prior to its delivery to staff and must provide practitioners not only with the necessary range of clinical holding skills required, but of equal importance, a sound legal and professional framework in which decisions about such practice can be made. Additionally, responsible training providers should work in partnership with commissioning organisations to provide on-going support and advice so as to ensure that there is an effective mechanism for implementing, reviewing and improving practice and patient outcomes.

Harris et al [3] provide a checklist of key topics that should be included within a training programme and suggest that poor or ineffective training will simply undermine staff morale and increase the risks to both staff and patients. Key features regarding the provision of training to practitioners include the specific underpinning knowledge and skills, and how they relate to the current regulatory frameworks and dentistry in practice. In particular, it is important that any training commissioned not only meets the recommendation of the Joint Guidance [5] and other relevant national benchmarks for good practice, but is also reflective of the commissioning organisations standards of professional practice. In accordance with the BILD Code of Practice [2], staff should receive training appropriate to their role and workplace which is followed by a minimum of a one day refresher course every twelve months in order to ensure good practice is promoted and maintained.

7. Practical Approaches

In general, the practical application of clinical holding should be used to promote the best interest of the patient in order to ensure that s/he receives the necessary treatment. Once it has been agreed that the use of specific holding is appropriate and justified in relation to the patient and the treatment identified, the practical application should be used within the concept of 'gradient of control', whereby the nature of the specific hold(s) applied should be proportionate to the actions/behaviour of the patient (and the risks associated with such action or behaviour). Any interventions should also be used for the minimum period of time in relation to the treatment or specific procedure taking place and as such may be applied for part or all of the treatment process depending upon the patient, their degree of co-operation or resistance, and the risks present. If the level of holding is too forceful, too restrictive, or maintained for prolonged periods of time, the patient might become distressed or agitated and begin to behave in ways that increase the risks of injury to all involved, as well as compromise the safety or the effectiveness of the treatment. In contrast, if the level of holding does not provide sufficient support or restriction, the patient may feel anxious and/or unsafe and attempt to move in a way that compromises the safety and effectiveness of the treatment.

Taking account of the above, lower level interventions are more likely to be accepted by the patient, practitioners, guardians, carers or on-lookers. From a practical perspective, holds should be applied with the least restrictive method first and only become more restrictive as the risks associated with the patient's behaviour increase. Whilst

the discussion, planning and the development of individual patient treatment plans helps to guide collaborative and safe practice, there will always be a degree of professional subjective judgement and decision making each time clinical holding is used.

In order to ensure that any intervention is applied within a clinical context in a safe manner, the staff resources should be commensurate with the level of support required or risk that needs to be managed. Whilst it is usual for the dentist to have a dental nurse, therapist or hygienist to assist with treatment, the professional application of clinical holding may require two or more people in order to be applied safely. In many situations parents and carers are often well placed to assist, not only in terms of providing information about the patient, but to provide assistance to support or hold the patient e.g. by the hand. However, parents or carers should not be asked to apply any specific approved technique because they have not received appropriate training and therefore may act in ways that are not compatible with the professional and safe holding of the patient. Whilst the involvement of parents or carers is typically an individual decision for each patient and dental practitioner, it is good practice to ensure that only those staff who have undertaken the specific training, and are thereby authorised to use such interventions by their employing organisation, engage in the application of clinical holding.

8. Post-Treatment Management

Post-treatment management can be viewed from three interdependent perspectives:

(a) Care and support - the need to manage the physical and psychological well being of the patient and those people involved in the application of the holding:

Understandably, the use of clinical holding can become distressing for the patient and practitioners especially in situations where the patient is held in a restrictive manner. Regardless of any legal or professional justification, it is possible that some patients and practitioners may experience physical and/or psychological trauma. This important acknowledgement requires that every effort should be made to minimise the potential negative impact from the use of any intervention by ensuring that both patients and practitioners have an appropriate level of support post-treatment. Whilst busy dental clinics may not be suitable places for appropriate support to be provided organisations, nevertheless have an obligation to consider how individual patients' and staff can be supported.

(b) Record keeping - the need to accurately report and document what occurred:

As with all patient treatment, it is important that the use of clinical holding is fully documented, not only within the patient's individual dental plan as part of the planned decision making process, but also after each intervention. Accurate records not only demonstrate due diligence by practitioners, they can be used to evidence compliance with statutory or regulatory requirements, can help inform future decisions about the patient's treatment, and can also be used establish trends and patterns in terms of effective or ineffective strategies.

The Joint Guidance [5] states that the use of all physical interventions (whether planned or unplanned) should be recorded as quickly as practicable, in any event within 24 hours of the incident occurring, by the person (s) involved. Specifically the written record should include:

- the names of staff and the patient involved;
- the reason for using clinical holding rather than another strategy;
- the type of intervention employed;
- the date and duration of the intervention; and

- whether the patient or anyone else involved, sustained injury or distress and any action taken as a result.

Record keeping is also essential in terms of the wider organisational strategies aimed at preventing the misuse or abuse of physical interventions as well as safeguarding vulnerable children, young people and adults.

(c) Engagement and learning - the need to include the patient and appropriate others in a review and evaluation of the event, ensuring that any learning gained from the intervention is used to improve the future care and treatment of the patient, or service provision:

In additional to organisational policy on the use of clinical holding, robust recording mechanisms should help to provide evidence that effective outcomes are being delivered and any areas of poor practice are quickly addressed. Key to post-treatment management is the need to establish mechanisms whereby the process and outcomes of treatment is used to inform and improve the future treatment of the patient, and/or service provision.

Appendix 1: Case Study Examples of Good Practice

Case Study 1

Jane

Jane has Sturge Weber syndrome. She has moderate learning disability, is profoundly deaf and has sight in her left eye only. She has a haemangioma on her right hand side of her face which extends to involve the intra-oral tissues. She becomes very irritated and agitated if she is approached suddenly or if anyone attempts to look into her mouth from her right side. Jane's parents advise the dental team that she is reasonably compliant and cooperative if approached from the left side. She also finds tooth brushing acceptable if she is given a face mirror in her right hand and if the person assisting with brushing offers to guide (hand on hand) the toothbrush held in Jane's left hand. Jane's parents say that although she lets people know when she wants things to stop, by dropping the brush and closing her mouth, she will usually tolerate further attempts if thing are taken slowly and she is allowed frequent breaks.

Case Study 2

Andrew

Andrew has a learning disability, lives in a small residential home and attends for regular routine check-up having previously had most invasive dental care provided under general anaesthesia. He is reasonably cooperative for brief examination but has unpredictable movements and resists protracted oral examination. You note a carious lesion on the buccal surface of a lower canine tooth. Andrew has limited understanding and lacks the capacity to understand his treatment options. Whilst the treatment of this accessible lesion is not urgent it does need to be completed. Examination of lateral oblique radiographs does not reveal any other pathology.

In discussion with carers, agreement is reached to consult with his parents, who live elsewhere, and reach a best interests decision. Following this discussion, a treatment plan with a range of treatment options is agreed based on Andrew's current clinical and his inability to consent due to a lack of capacity.

Using a 'least restrictive' approach, the treatment plan proposes that an initial course of action will be to attempt to restore the accessible carious lesion using a combination of Carisolv™ and atraumatic restorative techniques (ART). This part of the treatment plan also includes the need for assistance from other members of the dental team, who use clinical holding techniques to limit Andrew's unpredictable movements in order to maintain his safety and the safety of the dental team.

The option for general anaesthesia is consider inappropriate but the dental team do agree that IV sedation may be used as the second alternative treatment option if the first, more conservation approach, is unsuccessful.

Finally, if this second treatment option is unsuccessful, the dental team agree that the lesion may be treated with topical fluoride varnish and any further invasive treatment deferred until it is judged that dental and/or other treatment is required and recourse to general anaesthesia may be considered.

Case Study 3

Peter

Peter has early onset dementia and lives at home with his wife and daughter, who are his main carers. Peter's wife is concerned about his oral health. He has lost many of his personal care skills and is no longer able to brush his own teeth. Although his wife attends to most of his personal care needs at present, Peter is often unwilling to let her brush his teeth without some degree of difficulty or struggle. Peter gets easily distressed, pushes her away or holds onto her hands to prevent her from placing the toothbrush in his mouth.

Peter's wife is very concerned about his oral health and she feels that she has reached a dilemma. She feels that if she continues to try and brush his teeth in the current manner, she may hurt him or make him angry and therefore less willing to accept any future attempts. She is also concerned that she does not neglect Peter's oral health and is asking the dental team what can be done.

In discussion, it emerges that Peter's level of cooperation changes throughout the day. He is usually more cooperative in the morning, but his level of compliance diminishes after breakfast and is lost almost entirely by the evening. It is agreed that his wife should concentrate on brushing Peter's teeth in the morning when he is most cooperative or tolerant of her support and that she should still encourage him to brush his own teeth as much as possible (when he is willing) using a 'hand on hand' technique. It is also recommended that a 'Superbrush' or Collis Curve, with the facility to brush three surfaces at the same time, may expedite effective oral hygiene. Peter's wife is shown how to do this and is also shown how her daughter may help by limiting Peter's hand/arm movements so that his wife can brush his teeth in a safer manner without the fear of Peter hitting her.

Case Study 4

Shazir

Shazir is 22 and has severe learning disabilities and lives in a residential home for young adults. She is brought into surgery because her carers think she may have a problem with her teeth because she has been slapping the side of her face and crying which the carers describe as 'unusual'. Examination is very difficult and Shazir is very uncooperative. It is likely that she has not received any oral care for a number of years and has a generally neglected mouth. There are heavy deposits of calculus both supra and sub-gingival and she has a fractured premolar tooth. During the examination, the carers offer to 'hold her down' as they say this is frequently require when attending to all her personal care needs.. The dentist is concerned that Shazir is extremely frightened by the clinic room and the examination, and also has a possible phobia – her eyes are wide and she makes constant noises of distress. The carers feel that she would benefit from a general anaesthetic so that she can have the appropriate treatment as quickly as possible and offer to hold her down.

The dentist decides not to progress with any further treatment at this point since any attempts at scaling are likely to be ineffectual. There is also some concern that the carers at the residential home may not be adequately attempting to assist Shazir with her daily oral hygiene and thus maintain in-surgery efforts to provide effective treatment. There is also concern that the carers may be making an assumption that she is hitting her face because of a problem with her teeth rather than consider other factors which may be affecting her behaviour.

An appointment is made with the manager of the residential home, the carers, Shazir's next of kin and the dental team to discuss plans for her long term oral care.

Case Study 5

Robert

Robert has cerebral palsy and attends regularly for check up. His movements are athetoid, characterised by involuntary movements of his fingers, hands, toes and feet as well as uncontrolled movements of his arms. Robert's speech is also severe affected and although it is quite difficult to understand him, he refuses to use and augmentative communication methods. Although he wife usually accompanies him to the surgery, he can get quite angry if she attempts to explain what he is saying to others and as such, over a period of time, the dental team and become quite skilled in understanding him.

During his last course of treatment, his movements were particularly uncontrolled and there was a point where the dental team were concerned that the treatment could not be performed safely. A discussion was held with Robert whom requested that the dental team hold his hand and arms to prevent him accidentally hitting the dentist. The dental team were concerned about holding Robert, partly because of the concern they may injury him because of his cerebral palsy and partly because they felt it was difficult to always understand him and they would not be able to understand his requests to stop if the procedure became uncomfortable for him. After further discussion, it was agreed that the team would hold Robert, but only during treatment, and that his wife would always be present as she could fully understand Robert's speech. The team also agreed that they would stop what they were doing if Robert made any request to do so or made any vocalisation. This was to enable everyone to check that Robert was feeling comfortable and that he was still providing consent for the staff to continue to hold him. The discussion was documented in his notes and the treatment was carried out successfully.

Case Study 6

James

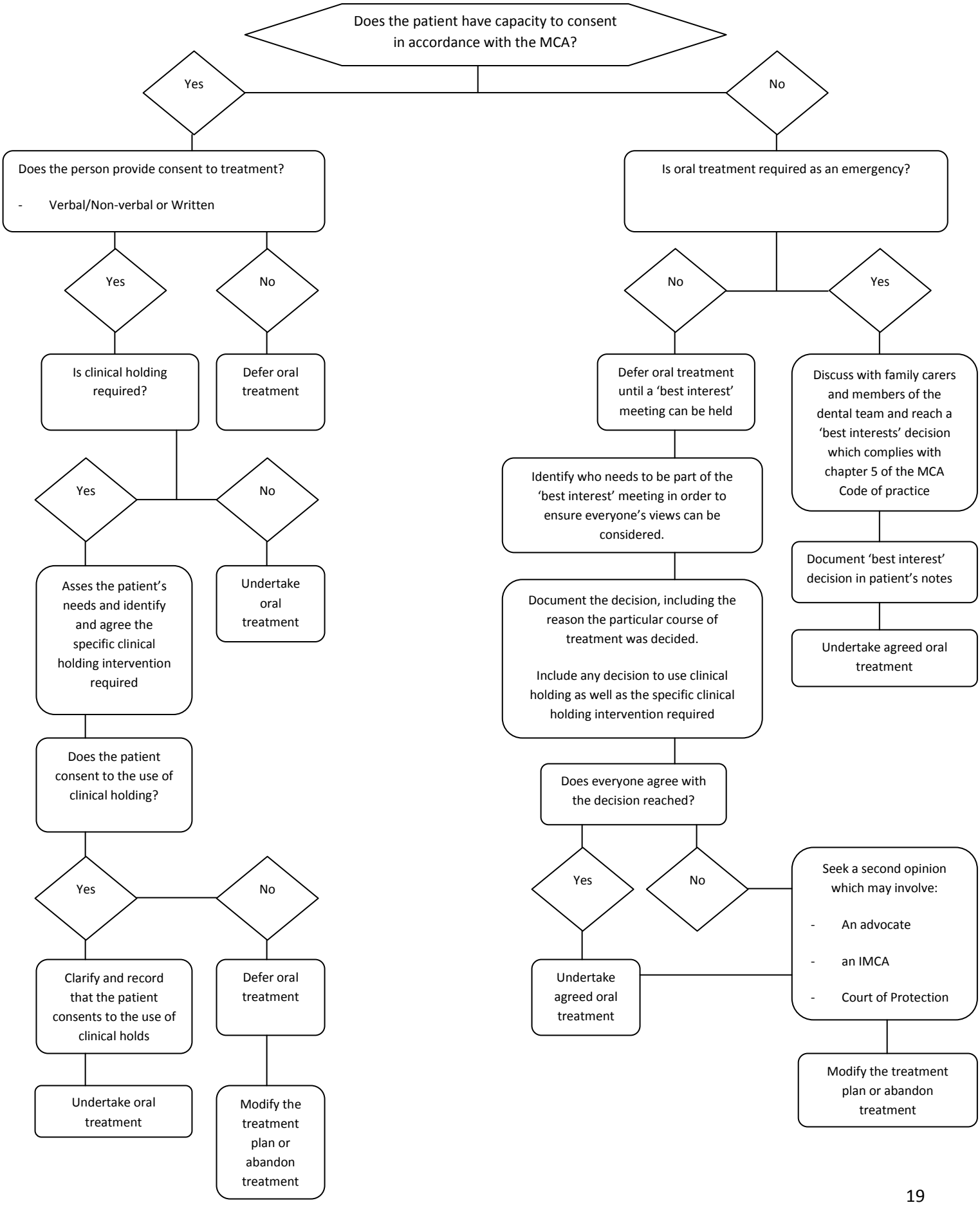
James has brain injury following an accident at work. This has left him with some changes to his personality (he has become disinhibited, will shout, swear, and use foul or abusive language) as well as some physical weakness to his left arm and leg. He is no longer able to attend to his day to day personal care needs and is at risk because he does not appear to comprehend danger. Sadly, his wife left him due to the pressure of providing full time care and James is now divorced. James is now in a long term care but still maintains regular contact with his parents. Since his accident, it has been very difficult to provide James with appropriate oral care at home and in the surgery. He will not allow his carers to brush his teeth at all, and is totally uncooperative with the dental team who have been unable to undertake an oral examination for some time. Recently, James has been very unsettled and is refusing to eat. His face has a slight swelling and his carers feel that he may have an abscess or other oral problem. James has been prescribed pain killers and antibiotics by his G.P. but this does not appear to have helped, particularly as it is very difficult for the carers to encourage James to take his medication.

Initially the dental team attempt to examine James, but as before this proves unsuccessful. A best interests meeting is held and following discussions with his carers and parents it is agreed to conduct a full oral examination under a general aesthetic so that immediate treatment can be provided. The carers raise concern that James is likely to be very uncooperative during the anaesthetic, so it is agreed to use some clinical holding techniques to prevent James from harming himself or others. Specific techniques are identified and demonstrated to his parents

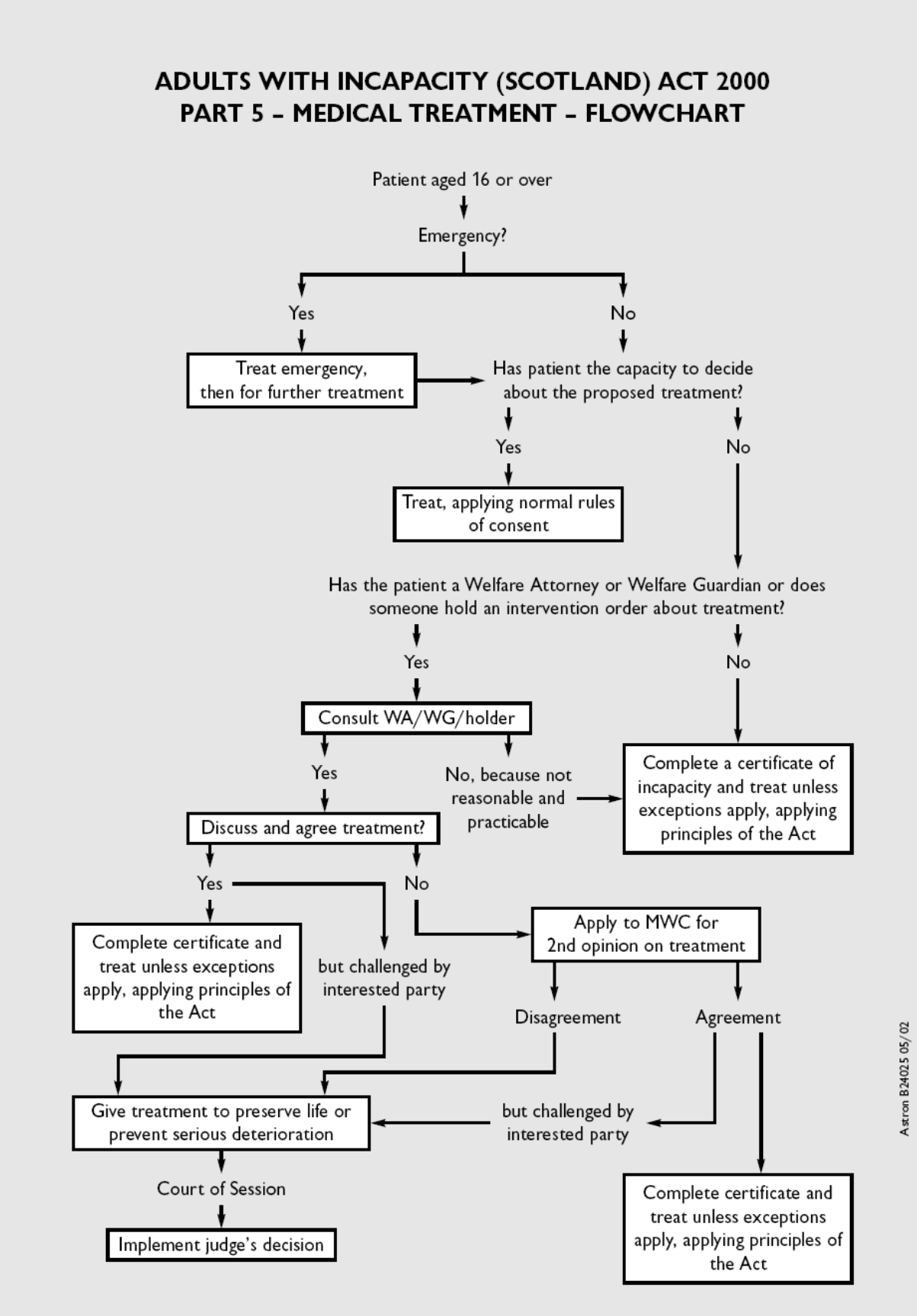
and carers and everyone agrees that these should be used, but only in the event that James becomes uncooperative. A number of other treatment options are also identified in order that the dental team can work together with James and his carers on his long term oral health care. The decision to asses and if necessary treat under an anaesthetic is fully documented in James clinical notes, as is the decision to use clinical holding.

James is brought in for planned surgery and the dental team prepare in advance to ensure that they are prepared for all considered eventualities. Two of the dental team assist James onto the trolley in preparation for the anaesthetic and use the agreed holds to limit his ability to strike out or hold onto the anaesthetist. The induction takes place safely and James treatment is completed without injury or harm to him or the dental team.

Appendix 2: Capacity to Consent (Flow Chart for England and Wales)



Appendix 3: Capacity to Consent (Flow Chart for Scotland)



Appendix 4: Example Communication Plan

Communication and support plan	
Name:	Date of birth:
Residence/ carer:	
Identified risk(s)	
Communication (methods of communicating with individual)	
Environment (eg. timing, surroundings, people, music)	
Management plan (physical intervention; other behaviour modification)	

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