Holding children still for clinical procedures.

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Objectives

• Explore the challenges faced in clinical practice relating to children undergoing clinical procedures.

• Critically examine the role of professional guidance in everyday practice.

• Provide an overview of research relating to the holding of children for a clinical procedure.

• Examine what good practice may look like.
What do we mean by ‘clinical holding’?

- Therapeutic holding
- Restrictive physical intervention
- Supportive holding
- Comfort positioning
- Immobilisation
- Restraint

- Not relating to challenging behaviour or mental health provision.
What do we mean by clinical procedures?

- X-rays
- Dressing changes
- Administration of medication
- Blood sampling and cannulation
- Examinations and observations
Going to draw on evidence from 3 research projects and relate these to other evidence

- Bray, L., Carter, B & Snodin, J
  - Observational (n=31) and interview study (22 health professionals, 21 parents and 4 children)

- Bray, L., Carter, B., Ford, K., Dickinson, A & Water, T
  - International survey of health professionals reported holding of children for procedures
  - 872 responses; nurses, doctors, anaesthetists, education, psychologists, play/life therapists

- Bray, L., Carter, B & Snodin, J
  - Narrative synthesis review
  - Ethical consideration of the evidence

Holding Children for Clinical Procedures: Perseverance in Spite of or Persevering to be Child-Centered
Lacy Bray, Bevan Carter, Jil Snodin

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Holding and restraining children for clinical procedures within an acute care setting: an ethical consideration of the evidence
Lacy Bray & Bevan Carter
Children undergoing non-critical procedures in pre-hospital care
Chris Preston

Experiences of being held for procedures: children and young people with long-term conditions
Jill Snodin

Health professionals actions and decisions to start, continue or stop holding a child for a clinical procedure
Sara Melville

Experiences of children, young people with intellectual disabilities and their parents of undergoing clinical procedures
Greg Cigan

How do children communicate assent and dissent when having a radiological procedure
Holly Saron

Making a drama out of a procedure. Developing an understanding of what good and bad looks like from a child’s perspective. Lucy Bray, Bernie Carter and Ed Horowicz

Ongoing work
What we do in practice....
What happens in practice?

- When were you last involved in a procedure where a child was held against their wishes (crying, struggling, saying no or telling you to go away)?
  - Within the last week
  - Within the last month
  - Within the last 6 months
  - Never

- What happened during this procedure?
- What was your role?
What do you picture when you think of a child having a procedure?
Scenario group work
Is there anything you would change about this procedure?

If so, what could be done differently?

Scenario 1: Two-year-old boy having an X-ray.
Is there anything you would change about this procedure?

If so, what could be done differently?

Scenario 2: 7 year old girl having an injection
How often are children held still for clinical procedures?

Holding children is reported by health professionals as a frequent and accepted part of clinical practice.

Children were reported as being held:

- Very often (n=286)
- Quite often (n=411)
- Not often (n=163)
What influences our actions and decisions about a child who is likely to be un-cooperative and needs to be held?

- Child’s age – ‘they are too young to understand’
- Child’s behaviour – ‘they are already crying in the waiting room’
- Parents’ behaviour – focussed on getting it done and getting back to work
- Child’s previous experience – ‘he always kicks off’
- Nature of procedure –
  - ‘It does not even hurt’
  - ‘kids are never going to sit still and have a blood test’

Do these effect what decisions and actions we take?
What does research tell us about children being held for procedures?

- Health professionals and parents find holding children against their wishes distressing as it breaches their trusting relationship (Lloyd et al. 2008, Bricher 1999a, b).
- It is seen to be a necessary but unwelcome part of working with children.
- Being held against their wishes can result in children experiencing short-term distress and long-term negative psychosocial development (Duff et al 2012).
Are there options or is it inevitable that children will be held?

- “Dad says he always screams, he’s done it lots of times, so dad said we’re best getting on with it” (HP).
- “We don’t use any force or method which requires force because kids don’t like to be held down and I think it is counterproductive—so usually with the help of parents who can hold the child down (HP).”
- “Best to just to get it over with and just do it quick and then that way she hasn’t got time really to be traumatized and kick off even worse” (HP).

Bray, L., Carter, B & Snodin, J (2015) Holding Children for Clinical Procedures: Perseverance in Spite of or Persevering to be Child-Centered. Research in Nursing and Health (Bricher 1999a,b; Lloyd et al. 2008; Homer and Bass 2010)
Ranking exercise to explore the challenges faced in every day practice

What are the top 2 challenges professionals face when working with children having procedures?
What we should do, or what should we do?
What resources/guidance/policies inform practice?
What does professional guidance tell us about holding children for procedures?

BMA 2016 – holding or restraining a child against their will “should only be used when it is necessary to give essential treatment or to prevent a child from significantly injuring himself or herself or others”.

RCN 2010 – “the use of restrictive physical interventions or therapeutic holding without the child/young person’s consent should only be used as a last resort and not the first line of intervention”.

Paediatric Psychology Network Guidelines (British Psychological Society 2012) “holding the child in a comfortable position during a procedure can help him/her to feel more secure and can produce significantly lower levels of distress”.

Local guidelines and policies

DoH draft guidance on reducing the need for restraint and restrictive intervention for children and young people with learning disabilities, autistic spectrum disorder and mental health needs.
In reality...

- Established practice within the workplace
- Personal and professional boundaries

Research suggests there is a lack of clarity, lack of evidence & lack of clear professional guidance as to what to do when faced with a child who is uncooperative and needs a procedure undertaking.

- 32% had access to resources
- 37% of respondents were unsure if there were resources to guide their practice,
- 30% could not identify resources within their clinical setting.

What does professional guidance tell us about seeking approvals for holding children for procedures?

- When a procedure is required in all but the very youngest children, obtain the child’s consent (Department of Health, 2001) or assent (expressed agreement) and for any situation which is not a real emergency seek the parent’s/carer’s consent, or the consent of an independent advocate.
In reality - obtaining permissions for holding a child for a procedure

Consent from parents

- Verbal or written consent obtained from a parent: 616
- Parental consent is not required: 118
- Unsure whether consent is required: 71

Assent from children

- Verbal or written assent obtained from child: 299
- Children's assent is not required: 266
- Unsure whether assent is required: 232

Bray, L., Carter, B., Ford, K., Dickinson, A, & Water, T
Research indicates that current practice is ‘tipped towards’ institutional norms and adults’ best interests with children’s rights being afforded less ‘weight’.
What might good practice look like?
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**Before a procedure**

- Make sure the parent/carer and child knows what is going to happen (age appropriate information) – who will be there, who will do what, how will they feel and what will they smell and hear (especially for older children), how long will it take (it will take as long as..), what will happen afterwards.

- Give parents a choice to be there or to leave (and be nearby) and to talk about how they can help their child through the procedure – supportive holding, distraction, remaining calm.

- Be honest with parents and children (if appropriate) that holding may be necessary and how this will be managed

- Are the right people in the room?

- Analgesia (local, oral)
What might good practice look like?

**During a procedure**

- Distraction
- Breathing techniques, relaxation
- Position a child upright (if possible)
- Try comfort positions (RCH)
- One voice (ONE VOICE 4 Kids, LLC 1996)
- If a child gets distressed
  - Take a break
  - Does the procedure really need to be done today?
The Front to Back Position

Comfort Positioning at Children's Mercy

The Side sitting Position

Comfort Positioning at Children's Mercy

The Straddle Position

Comfort Positioning at Children's Mercy
What might good practice look like?

After a procedure

- Reward and praise a child for things they did well.
- If the child was upset, stay with them until they are calm.
- Talk about why holding was needed (if it was) with child, parent and between professionals present (debrief).
A message to take back to our workplaces
Thank you!

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