Holding children for invasive procedures: preparing student nurses

A lack of standards for practice and education led Tracey Valler-Jones and Andrea Shinnick to develop a teaching session on restraint for first year students

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KEY WORDS

Nursing: children, Standards and guidelines, Education: practical experience, Restraint

Holding children for invasive procedures is well covered in the literature in relation to techniques (British Institute of Learning Disability (BILD) 2001, RCN 1999), policy (BILD 2001, Lambrenos and McArthur 2003), appropriateness (Collier and Pattison 1997, Robinson and Collier 1997), parental involvement (Kurfis Stephens *et al* 1999) and consent (Brook 2000). However, little research has been undertaken to address how student nurses are involved (Bland *et al* 2002).

A survey of clinical areas used by the University of Central England for child branch student placements revealed that qualified nurses believed that students should develop the skill of holding children for invasive procedures during their first year of training. Students' evaluations following their first placement stated that they had been involved in restraining a child. Informal discussions with students identified that they felt uncomfortable with this practice in the absence of formal training, but as junior members of staff they felt unable to question rationales and practice.

This article describes an approach to skills development in this area provided for student nurses (Dip HE and BSc) who have chosen children's nursing as their preferred branch. The students receive this training in a child-specific skills module following their first placement, around five to six months into training. Skills sessions are provided over the whole course but here we concentrate on the initial training in the module.

Definitions

The RCN (2003) defines holding as 'immobilisation, which may be by splinting or by using force. It is a method of helping people, especially children, with their permission, to manage a painful procedure quickly and effectively. Holding is distinguished from restraint by the degree of force required and the intention (p4).'

There is no precise legal definition of restraint. In broad terms, it means restricting someone's liberty or preventing him or her from doing something they want to do. In general, restraint is described as an intervention that prevents a person from behaving in 'ways that threaten or cause harm to themselves, others or to property' (Duff *et al* 1996). Restraint is defined by the Department of Health (2002) as the positive application of force. By definition, restraint is applied without the person's consent.

There are three broad categories of physical intervention (Harris 1996):

- direct physical contact between a carer and the individual
- the use of barriers, such as locked doors, to limit freedom of movement
- materials or equipment which restrict or prevent movement.

Aims and objectives

The main challenge in planning the teaching session was to ensure a balance between theory and practice and to make students aware of the difficulties clinical and teaching staff face in relation to the validity, efficiency and acceptability of the holding procedures.

SCIENCE PHOTOLIBRARY

Students require knowledge and skills to carry out the practical aspects of holding children for invasive procedures within a safe system of work. The objectives of the session are to inform students about good practice, engage them in debate on the subject and help them identify the risks to the child and themselves of any holding procedures. They are reminded that not all children need to be held or restrained: the emphasis of the session is on safe and informed practice for those that do.

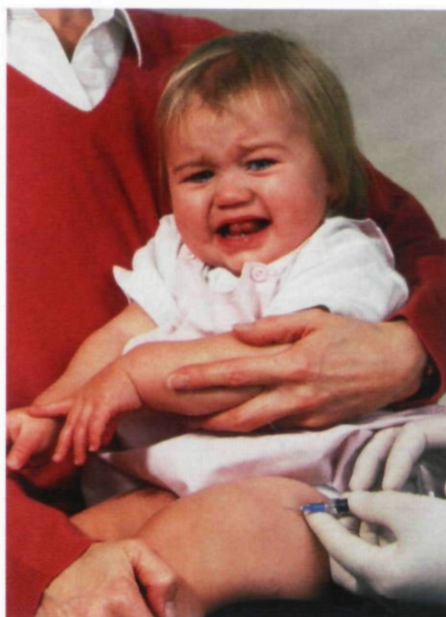
There has been little research on how to teach restraint and holding skills (Bland 2001, Ellis 2000). National reports and enquiries have highlighted a lack of systematic evidence and inconsistencies in the quality and content of training (and skills of trainers) on this subject (NIMHE 2004). Until there is a national educational standard, we will follow recommendations from Allen (2001), Bell and Stark (1998), BILD (2001), the Education Act (1996) and NIMHE (2004). We used the work of Kolb (1984) to design the teaching strategy.

Educational strategy

Educational courses can be described as either practical (involving doing) or theoretical (involving thinking). Both types of courses have limited success (Kolb 1984). Learning from experience requires links between doing and thinking and involves four stages – see figure 1. The learner can enter the cycle at any point but the stages must be followed in sequence. It is our experience that students do not have the opportunity or ability to actively experiment and therefore miss out on this stage of the cycle.

Learning activities are planned to allow the student to move through the four stages of the Kolb model. There are opportunities for students to:

- think about the subject (group work where they answer set questions and read articles prepared for them)
- reflect on their experiences during placement through role-play
- plan and practice holding techniques – giving the student an opportunity to make mistakes safely and challenge the



perception and validity of current practices and beliefs in this area.

Practice standards

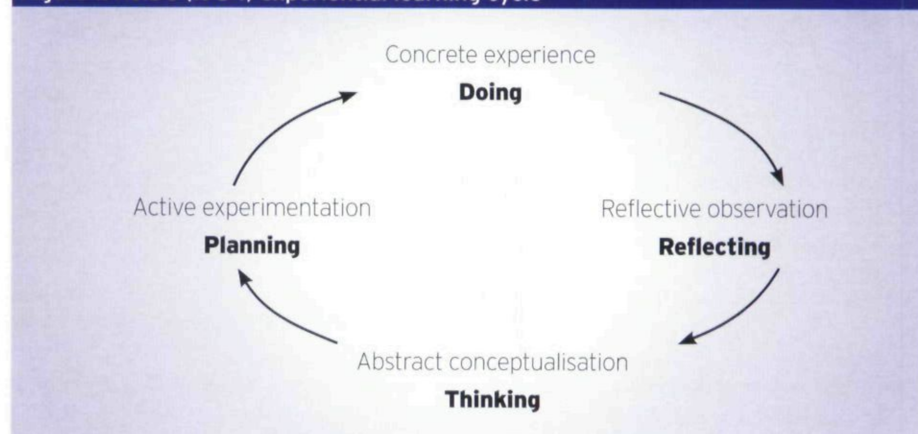
Despite a comprehensive literature search, we were unable to uncover any articles addressing techniques, acceptability and efficiency. We did find many articles on physical intervention techniques particularly in the field of learning disabilities. It would appear that holding techniques are developed over time by nurses who gain experience by being involved in the first place. This raises the question of what guidelines they are working to; who has designated these techniques safe and acceptable?

In the absence of formal guidelines, we developed our own standards with the help of a parent and experienced nurses and lecturers from all four branches of nursing (some of whom are registered with external bodies involved in the management of violence and aggression, teaching of physical intervention skills and non crisis interventions). We used guidelines from BILD (2001) and the Human Rights Act (1998). Each holding technique was role-played and analysed in terms of meeting the Code of Professional Conduct (NMC 2004). They were photographed and documented as the standard for teaching and to ensure consistency from one cohort to another.

> Students are taught how holding techniques need not use unnecessary force, cause pain or put pressure on joints

Leading professionals have been debating many of these issues via the Internet and since June 2004 a mailing list has been set up to provide an open forum for discussions on physical interventions (*pi-training@jiscmail.ac.uk*). Areas of discussion have included legalities, the difficulty of establishing credentials of trainers, acceptability and efficiency of practices and the need to continue debating and publishing findings. While this does not replace the need for official recognition via a regulatory body, this forum

Figure 1. Kolb's (1984) experiential learning cycle



Box 1. Questions for group discussion

Who is legally responsible for deciding the method of restraint and the actual holding of the child?
How old does a child need to be before they can consent to treatment?
What factors will influence your decision to hold a child?
Should parents/legal guardians be involved in holding their child? Explain your answer
What other methods could be used other than holding techniques?
Articles provided to support discussion: Robinson and Collier (1997), Collier and Pattison (1997), Kurfis Stephens *et al* (1999), Lambrenos and McArthur (2003)

Box 2. Role play

Holding babies, infants and children for:
Taking blood (in arm, in hand)
Eye-drops
Ear-drops
Administration of injections (immobilisation of limb, upper outer quadrant)
Lumbar puncture

provides reassurance and support for staff involved in the practice or teaching of holding children for procedures and physical interventions.

Plan of the session

During the two-hour teaching session the students initially work in groups to answer one of five set questions (see box 1) and then role-play practical situations (see box 2). Group feedback and discussion helps to identify practice issues. Holding techniques are taught through identifying:

- risks of any positions (physical and emotional, to both child and carer)
- recommendations for how to hold the child correctly to minimise adverse effects of the intervention.

In the practical session, teachers and students problem solve the practice issues in small groups. Students reflect on whether they have been involved with holding/restraining children and interventions that required the child to be held or restrained. They are guided to develop safe and informed practice using the photographs and the standards. Discussion includes the natural range of movement that the child may have and how holding techniques need not use unnecessary force, cause pain or involve putting any pressure on joints. The role-play creates a vivid mental imagery that the student strongly associates with precisely those performances most likely to benefit and sustain the knowledge gained (Marks 1999).

Conclusion

This teaching session has been evaluated extremely well by students; informal feedback is requested at the end of the session and formal evaluation is carried out using the university evaluation guidelines. Before each module we undertake a literature search to ensure that the information given includes all of the latest developments but there is still very little guidance or reports of evidence-based practice in this area. We would like to develop links with colleagues in clinical and academic circles who are concerned with this topic to work towards a national evaluation of techniques used in practice and of the training practices delivered with a view to establishing benchmarks for good practice PN

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