# Clinical holding: ethical guidance for children's nurses working in the UK

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## Abstract

This article explores ethical decision-making surrounding clinical holding of children and young people in healthcare environments with the aim of enhancing autonomy and engagement on their behalf. A considerable body of evidence, published over the last 20 years, suggests that this complex and challenging area of practice is not always well managed, with mixed messages about the nature of consent, choice and negotiated practice countered by best interests decisions taking precedence ahead of the child's wishes.

An ethical framework is proposed comprising four levels of value-based interventions and how they may be applied in clinical practice, allowing for increased engagement, empowerment and support on behalf of children and young people in relation to clinical holding decisions.

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## Keywords

autonomy, child health, consent, decision-making, ethical issues

NURSES AND healthcare professionals routinely use holds to help a child or young person stay still while examinations or treatments are being undertaken or to prevent treatment interference, that can sometimes be invasive. The use of holds in this way is often termed clinical holding, therapeutic holding or restraint. It helps to keep the child safe and ensures that they receive appropriate care.

Nurses have said that clinical holding is vital to position a child so that a medical procedure can be carried out in a safe and effective manner (Bray et al 2015, Page 2015). Some of these treatments are emergencies, but others present no short-term risk of imminent harm and any form of holding should be considered a last resort. There is a need, therefore, for a distinction to be made between the appropriate and inappropriate use of clinical holding, and this article draws on case studies to distinguish between acceptable approaches and those methods that should no longer be supported in practice. The aim is to provide nurses and healthcare staff with recommendations for clinical holding that answer the following possible questions:

- Do I feel satisfied with my care delivery?
- Could I justify my care decisions to a third party?
- If I were giving this care again, what would I do differently and how would I achieve this?
- How flexible have I been in my decision-making?

This article also provides an opportunity for greater critical reflexivity through consideration of these questions.

For healthcare professionals, the rights of children or young people as active participants in their care is increasingly being emphasised, but when clinical holding is used the child or young person's views and preferences can become secondary to the decision-making of adults involved in their care and treatment.

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In clinical settings, the ethical argument for holding a child or young person while undertaking a medical procedure or examination is that the procedure may be ineffective if the child or young person is free to move. It is not uncommon for children to resist being held (Bray et al 2016), which often leads to more force being applied to keep them still. In philosophical terms, the 'end justifies the means' argument is utilitarian in nature (Nussbaum 2006), and it is a relatively simple utilitarian argument that the 'good' of a procedure working is more important than the 'evil' of temporarily holding a child or young person (Brenner 2007).

Basic rights of autonomy are often waived in healthcare settings in a way that would be unacceptable in other areas of society (Nussbaum 2006). However, if respect for autonomy underlies all human interaction, healthcare professionals must always consider the arguments behind limiting an individual's right to autonomy and find the least intrusive intervention (Nussbaum 2006). Furthermore, children with disabilities or impairments, such as the child with cerebral palsy who needs help to remain still or the child with a learning disability who is deemed unable to understand the purpose of a procedure, are more often subject to clinical holding than children without disabilities or impairments (Selekman and Snyder 1996, Robinson and Collier 1997, Souders et al 2002).

## The 'double bind'

In the UK, there are many examples of mixed messages about holding influencing the application of techniques. Healthcare guidelines may appear contradictory, or offer a choice of techniques that are equally unacceptable or unpleasant. This is known as a 'double-bind' situation (Bateson et al 1956). A double bind is the dilemma that occurs when two different sets of instructions are given by the same source, such that to obey one set of instructions is to disobey the other. It is a 'no-win' situation, in which the nurse concerned is 'damned if they do and damned if they don't' (Gibney 2006).

Royal College of Nursing (RCN) (2010) guidance implies that clinical holding requires the child's consent. It states: 'Therapeutic holding may be a method of helping children, with their permission. Practitioners should be aware that therapeutic holding if applied inappropriately and without the child's consent or assent can result in the child/young person feeling out of control, anxious and distressed.' However, attention is given to emergencies, with the following suggesting that consent may not be obtained due to time constraints and the urgency of the situation: 'Therapeutic holding without the child's consent or assent may need to be undertaken against the child's wishes to perform an emergency or urgent intervention in a safe and controlled manner – for example, to perform a lumbar puncture' (RCN 2010).

Determining when a child or young person can say 'No' is usually easier when treatment is deemed urgent, but there are many situations that are not emergencies in which holding a child for treatment may be beneficial, such as taking blood for health screening. This gives rise to the double bind.

The nature and context of treatment have significant effects on healthcare professionals' decision-making over clinical holding. Page and McDonnell (2013) state that some nurses and allied health professionals had become indifferent toward the practice of therapeutic holding, demonstrating uninterest in clinical holding as a skill. While Bray et al (2015) suggest that holding has become an 'invisible practice'.

From an ethical perspective, these statements imply that the ethics of holding are not being discussed. It is accepted that, if a child or young person in a life-threatening situation does not consent nor cooperate with a procedure, it is appropriate to use enough force to complete the procedure safely and effectively and achieve a successful outcome. However, some professionals believe that, if a child or young person does not consent to a procedure, it should not be undertaken. Instead, there should be a delay in treating the child while alternatives are sought (Jeffery 2002, Tomlinson 2004, Coyne 2006, Brenner 2007). Yet a delay in treatment could adversely affect the child or young person (Leroy and ten Hoopen 2012).

## Best interests

Page and McDonnell (2013, 2015) state that most healthcare professionals and academic lecturers who teach holding techniques to nurses achieve the necessary level of immobility in infants or toddlers by wrapping them in a blanket. However, dilemmas arise with older children who resist being held, struggle, cry or tell the people holding them 'no' or 'stop'.

Historically, it was assumed that healthcare professionals knew how children think and feel about their treatment and care (Hallström and Elander 2004), and Robinson and Collier (1997) and Tomlinson (2004) point out

## Key points

- The clinical holding of children and young people in healthcare settings is a complex and sensitive area of practice with ethical considerations often not emphasised in terms of decision-making
- Evidence indicates that valid concerns in this area of practice have not been adequately addressed, with little effective progress apparent
- An ethical framework such as that outlined here can assist children's nurses and other health professionals with decision-making in this area of practice


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that holding is often justified by the need to protect the child. However, Charles-Edwards (2003) argues that this justification takes no account of the objecting child who does not want the procedure to be undertaken, nor the pressure parents may be under when informed that a specific examination or treatment will help their child. More recently, evidence on shared decision-making suggests there are circumstances when parents are more prepared to relinquish responsibility for decision-making to health professionals (Coyne et al 2014).

Most of the literature on the use of 'restraint' relates to adult care, especially that of older adults, or those with learning disabilities or mental health issues (Page 2015). Little has been written on the incidence of, and justification for, the use of holding techniques in children's nursing (Brenner 2007), although this is beginning to change (Brenner et al 2014, Kirwan and Coyne 2016).

Charles-Edwards (2003) highlights the unequal power relationships between children and adults, including parents and healthcare professionals. Adults are presumed competent to make healthcare decisions unless there is evidence to suggest otherwise.

Children are often presumed to lack capacity to make such decisions, often without further enquiry as to whether they have the knowledge and ability to be involved in a decision-making process. However, an adult's assumption that a procedure is 'in the child's best interests' may deny the child an age-appropriate right to be involved in healthcare decisions and may conflict with the tenets of the United Nations (UN) Convention on the Rights of the Child (UN General Assembly 1989).

Consent applies to all patient care activities, including examinations, cannulations, dental treatments, injections or treatments for burns. In her exploration of the issues of power and vulnerability, Bricher (2000) identifies the development of trusting relationships as a major theme of the nursing narrative. Nurses found such relationships satisfying but were distressed if they could not maintain therapeutic relationships with children following instances of clinical holding.

Bricher (2000) suggests that these relationships often have an unequal basis in that, if a child did not want to proceed with a healthcare activity, the adult could 'pull rank' or take advantage of their seniority. Although children were given opportunities to go along with the nurse, refusal was not an option. Pulling rank raises complex issues about power relationships between adults and children, and about the term 'in the child's best interests'.

## Ethical guidance

Healthcare professionals put ethical principles into practice every day (Beauchamp and Childress 2013), but often experience double-bind situations. To help them decide what to do about holding, the authors propose four positions or 'arguments' for limiting autonomy, each of which leads to one of two interventions: holding or persuasion. This proposition extends the three positions suggested by Elvén (2017) and can be viewed as arguments for limiting autonomy as proposed by Nussbaum (2006). The arguments, which are illustrated by case studies, are of:

- Immediate danger.
- Probable danger.
- Care.
- Enhanced autonomy.

Each of the four positions, or arguments, are illustrated by a specific situation. They are important because a patient who can agree to being held, or who accepts the need for treatment or examination, may feel empowered and less apprehensive (Tingle and Cribb 2014). Autonomy is an ideal because there are situations in practice where capacity is undermined, but it remains an important feature in healthcare ethics because it underpins the concept of consent (Avery 2017). Nevertheless, children and young people are autonomous, and their wishes and opinions should be taken into account (Avery 2017).

### The argument of immediate danger

Around the world, laws allow the use of a considerable amount of force to avoid putting people in danger. For example, healthcare professionals will use force when holding a person bleeding from a major artery.

Case study 1 describes a young person rather than a child because issues of capacity and consent can become more problematic as a person gets older.

### Case study 1. Immediate danger

John is 15 years old and has been involved in a car accident. He is conscious but has substantial injuries that require immediate treatment. John says to the healthcare team: 'Leave me alone, do not touch me.' As his condition is life-threatening, the healthcare team decide immediately to hold him to provide a limited form of sedation and then proceed to treat his injuries.

In the circumstances described, it could be argued that John was actively refusing treatment at a time when his mental capacity to make such a decision could not be ascertained. Moreover, there were no clear alternatives to treatment. For these reasons the strongest argument is to use appropriate holds to continue treatment.

It should be noted, however, that if John had religious beliefs that preclude him from receiving a blood transfusion, for example, decisions on his treatment could differ. There are much wider issues surrounding whether religious beliefs are known or unknown, whether a parent or guardian are present to consent or whether hospital staff are working under loco parentis or duty of care rules but that is outside the scope of this article.

### The argument of probable danger

Some medical procedures are not urgent, but involve an element of risk. There is no immediate danger, but there could be if, for example, the child moves as soon as the procedure commences or if the child retracts consent in the middle of an invasive procedure. It is important that nurses and healthcare professionals decide on which procedures meet these criteria.

In case study 2, it is in Aisha's best interests that the team continues to obtain cerebrospinal fluid cultures rather than respond to her apparent withdrawal of consent. As the procedure of obtaining cerebrospinal fluid is dangerous if Aisha moves when the needle is inserted, the team holds her during the procedure. The team therefore uses a holding procedure that is safe and makes Aisha feel safe. Because of this the strongest argument is to use appropriate holds to continue treatment.

### Case study 2. Probable danger

Aisha, a three-year-old girl, is referred to the emergency department by her GP. She may have meningitis. After administering intravenous ceftriaxone, the team decide to perform an urgent lumbar puncture to obtain cerebrospinal fluid cultures, but Aisha shouts 'Stop' during the procedure.

### The argument of care

Healthcare professionals often limit people's right to autonomy to avoid future damage or suffering. However, this should not involve the use of force, so healthcare professionals must develop alternative methods to achieve compliance. These could include the involvement of a play specialist, motivational interviewing (Hettema et al 2005), relaxation techniques (massage or guided imagery), pharmacological preparations (analgesia, topical local anaesthesia or sedation), or distraction techniques, such as video games, mobile phone apps or music.

In case study 3, a systematic and hierarchical approach to reducing Jane's anxiety would be most helpful, and it is important to provide evidence of what is being attempted to alleviate her stress. If her health issues were to become more acute, the argument illustrated by this case study could change to one of probable danger. But otherwise, the strongest argument is not to use holding to obtain a blood sample.

### Case study 3. Care

Jane is 15 years old and has a learning disability and an autism spectrum disorder. She is also clinically obese and there is a history of ill health in her family. Her healthcare team want to take a non-urgent blood sample from her for analysis. Jane has tactile defensiveness – she reacts negatively to touch – and to date she has refused and physically resisted all attempts by healthcare professionals to take blood.

The argument of care therefore would work well with children and young people who are deemed by healthcare professionals and their parents to have the maturity and ability to make decisions about their care.

### The argument of enhanced autonomy

This is the broadest and weakest argument, but the most useful in everyday care. By deciding to use a given amount of force to ensure a child or young person has a procedure or treatment, healthcare professionals restrict that person's rights.

In case study 4, there is a possible long-term benefit to the individual that may warrant appropriate clinical holds to ensure that the intervention is safely carried out, but there is a need to justify such a decision. The team decided that Joe cannot be forced to accept treatment.

### Case study 4. Enhanced autonomy

Joe is ten years old. He has torn the meniscus cartilage in his knee while playing football and needs an arthroscopic meniscectomy. The healthcare team tell Joe that, if meniscus tears are not treated quickly, the overlying articular cartilage becomes worn out. However, Joe has been using a wheelchair, especially at school, which has given him assistance he would not usually have and this contributed to his reluctance to receive any surgical intervention to correct his injury. This has caused conflict among Joe's family, who think the most suitable way to deal with this situation is to transfer the responsibility to healthcare staff.

### FURTHER RESOURCES

Communication Skills Learning within Immersive Virtual Environments. This resource can also be used in preparing the child for the procedure and could enhance the consent process
**comslive.health.bcu.ac.uk**

Taking the Work Out of Blood Work: Helping Your Patient with Autism
**tinyurl.com/AutismSpeaks-blood-works**

Blood Tests for People with Learning Disabilities: Making Reasonable Adjustments
**tinyurl.com/PHE-blood-tests**


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Alternatives to restraining children for clinical procedures
**rcni.com/restraint-alternatives**
Developing a website to demonstrate clinical holding techniques
**rcni.com/holding-website**

By adopting an enhanced autonomy approach with Joe, supported by his family, he may accept treatment thereby preventing further injury.

There are many circumstances where routinely enhanced autonomy arguments are made without evidence to support them. In the case of holding there is the potential for people to fail to justify this position and for clinical holding to be subject to 'indifferent practice' (Page and McDonnell 2013).

When deciding on using a clinical hold correct methods should be applied.

Unfortunately, parents, carers or nursing students are often asked to hold the child without any previous instruction or frame of reference (Page 2015). The authors propose that if holding is considered, it should be performed by healthcare professionals and/or parents using the resources and instructions such as those found on the website created by Page et al (2017).

## Discussion

The authors acknowledge that the clinical holding of children is a complex and multifaceted area. The diversity of the case studies in this article illustrate the complexity and contextual factors that may influence safe and effective decision-making.

An implicit assumption has been to acknowledge the views of children, but in the UK consultation is not always routine (Bray et al 2015, 2016). In addition, the nature of consultation is subject to contextual variables, such as the child's age and developmental level, the specific context, and the urgency and long-term ramifications of a decision.

Supporting people to make decisions that involve an element of risk taking can also be subject to cognitive biases (Kahneman 2011). Cognitive bias occurs when people disregard rational analysis in complex decision-making processes, relying instead on past experiences or locally accepted rather than evidence-based practice.Reducing these biases often requires a process of challenge and a clear decision-making framework. In cases where consensus cannot be easily achieved, further discussion is vital. There can be little argument that holding in emergency situations should be viewed as different from other health contexts. Usually, decisions are made in situations where there is no immediate threat to life (Page 2015).

The ethical guidance proposed in this article relates to everyday practice and situations. It has several benefits and, by focusing on enhanced autonomy, healthcare professionals can at least minimise the number of potential double-bind situations they face.

The level of distress caused by the procedure is an important consideration. The child or young person may become distressed and cry or possibly try to hit the person applying the hold or the healthcare professional trying to administer treatment. These behaviours can hinder the ability to perform the procedure safely and increase the child or young person's pain and anxiety (Vannorsdall et al 2004). Such interventions also induce feelings of discomfort, stress and anxiety for the healthcare professional (Lloyd et al 2008, Seabra 2010).

In this argument healthcare professionals are faced with a situation where the child or young person needs the procedure or treatment but may be frightened. Some children and young people have needle phobias (Meltzer et al 2009), lack the mental capacity and maturity to make decisions about their care or there may be an uncertainty about the effect of delaying or not giving the proposed treatment which requires healthcare professionals to consider 'What is the best way to care for the patient at this time?'

## Conclusion

This ethical framework concerning clinical holds proposes different levels of value-based interventions in different situations. There is a danger that in some circumstances clinical holding for urgent treatment and interventions could be overused by nurses and healthcare professionals. Clinical holding should be viewed as a last resort and alternatives should be considered first where time is available.

Clinical holding for a procedure also requires nurses to consider if the procedure is necessary, and whether urgency in an emergency prohibits the exploration of alternatives (Bray et al 2015). 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/carer's consent, or the consent of an independent advocate.

Limiting the choices available to the child/young person can often help them to make a choice about clinical holding. Nurses and healthcare professionals need to be confident in their knowledge and practice of clinical holding to offer choices that assure a safe, effective, timely and appropriate intervention for all concerned.

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