Journal of Advanced Nursing

WILEY

JAN Leading Global Nursing Research

EMPIRICAL RESEARCH QUALITATIVE OPEN ACCESS

Parents' Experiences of Holding Their Child for Healthcare Procedures: A Qualitative Exploratory Study

Sage Hay[1,2] | Sharon Kinney[1,2] | Stacey Richards[1] | Fiona Newall[1,2] | Meaghan Hawley[1] | Jenny O'Neill[1,2]

[1]The Royal Children's Hospital, Melbourne, Victoria, Australia | [2]The University of Melbourne, Melbourne, Victoria, Australia

Correspondence: Sage Hay (sage.hay@rch.org.au)

Received: 4 December 2024 | **Revised:** 19 February 2025 | **Accepted:** 15 March 2025

Funding: The authors received no specific funding for this work.

Keywords: children | healthcare procedures | holding | hospital | nursing | paediatric | parent | qualitative research

ABSTRACT

Aim: To explore parents' experiences of holding children for healthcare procedures in an Australian paediatric hospital setting.

Design: A qualitative exploratory study was undertaken at a paediatric tertiary hospital in Melbourne, Australia.

Methods: Semi-structured interviews were conducted with parents of children who had undergone a procedure during their hospital admission. Interviews were audio recorded, transcribed and analysed using reflexive thematic analysis.

Results: Eight parents were interviewed, with four themes becoming apparent from their experiences, representing the multiple roles parents undertook when holding their child for a procedure. Parent as a *protector* was identified as the overarching role, with all roles involving aspects of parents protecting their child. The remaining roles included *comforter*—where parents supported their child by providing reassurance and being present; *helper*—where parents actively sought a role or stepped up to assist during a procedure and *enforcer*—where at times parents had a belief that to facilitate some procedures holding was necessary. A sliding-scale schema illustrates that these roles are not static, but rather positioned along a continuum, with some parents moving between roles throughout a procedure.

Conclusion: This study provided valuable insight into the complexity of parents' involvement when supporting their child during a procedure. The varying roles suggest parents balance the desire for their child to feel safe (holding as a comforter) with wanting to get the procedure done (holding as an enforcer).

Impact: This research impacts clinicians, parents and children involved in healthcare procedures. Clinicians can use the sliding-scale schema that illustrates the distinct roles parents can take on, as a visual tool to promote parental involvement and help parents define their role during a procedure.

Reporting Method: Consolidated Criteria for Reporting Qualitative Research (COREQ) guideline was utilised when reporting findings.

Patient or Public Contribution: No patient or public contribution.

1 | Introduction

In paediatric hospital settings, children frequently undergo a wide variety of healthcare procedures, such as peripheral vein cannulation (Svendsen et al. 2018), nasogastric tube insertion (Crellin et al. 2011), administration of medication (Brenner 2013) and medical imaging (Ng and Doyle 2019). In some instances, children may protest the procedure, become very distressed, or be unable to stay still, and therefore be perceived as uncooperative (Bray et al. 2015). To facilitate the completion of these procedures in a safe and efficient manner, a parent or healthcare professional may be required to hold a child (Bray et al. 2018;

Lambrenos and McArthur 2003). This type of holding remains a widespread practice in international healthcare settings (Bray et al. 2018; Coyne and Scott 2014; Kirwan and Coyne 2017).

2 | Background

Numerous terms are used to describe the practice of physical holding during healthcare procedures (da Silva et al. 2024). Terms include clinical holding (Lambrenos and McArthur 2003), therapeutic holding (Page and McDonnell 2015), supportive holding (Jeffery 2010), restriction (Brenner 2013) and procedural restraint (Crellin et al. 2011). Variation in terminology throughout literature reflects differing opinions about what holding involves, how practice should be described and the lack of an agreed definition (Østberg et al. 2024). In this study, we use 'holding' as a broad term when referring to a parent (person with parental responsibility or primary caregiver) or healthcare professional physically holding a child to limit their movement during a healthcare procedure.

Decisions to hold a child for a healthcare procedure are influenced by the child's age and type of procedure being completed (Brenner, Drennan, et al. 2014). Holding is more frequently used for preverbal and early verbal children (Crellin et al. 2011), those aged younger than 5 years (Brenner, Drennan, et al. 2014) and for procedures that are considered urgent (Bray et al. 2018). Additional factors include the child's level of distress (Lombart et al. 2020) and the safety of the child and others (Brenner, Treacy, et al. 2014). Nurses are often involved in procedures where children are held (Bray et al. 2018), with numerous qualitative studies describing their experiences as negative (Kirwan and Coyne 2017). Notably, nurses describe anxiety, fear and moral distress when holding children during procedures (Svendsen et al. 2017).

Parents are frequently present during a range of healthcare procedures (Crellin et al. 2011) and often assist in holding young children (Bray et al. 2018; Graham and Hardy 2004; Homer and Bass 2010). When holding their child, parents have described physical and emotional distress (McGrath et al. 2002) and feelings of anger and guilt (Brenner 2013). These feelings have been particularly apparent when parents felt unable to provide support to their child during a procedure to the extent they had wished to (Brenner 2013).

Previous studies have offered valuable insight into the emotional impact holding children for healthcare procedures can have on parents (McGrath et al. 2002; Brenner 2013); however, less is known about the defined roles parents take on in this context. Gaining insight into parental experiences across procedural settings is particularly important, as parents are key partners when providing patient family-centred care (Institute for Patient- and Family-Centered Care [IPFCC] n.d.) and typically the primary support for their child's emotional and physical well-being (Breiner et al. 2016). Through this study, a strengthened understanding of parental experiences will inform future development of targeted interventions aimed at enhancing procedural support for both children and parents. Such interventions could contribute to reducing negative emotions and trauma for children, families and clinicians involved in healthcare procedures within paediatric settings. By completing this study, researchers sought to answer the research question: What are the experiences of parents who have held their child for a healthcare procedure within a paediatric hospital setting?

3 | The Study

3.1 | Aim

To explore parents' experiences of holding their child for healthcare procedures in an Australian paediatric hospital setting.

4 | Methods

4.1 | Design

This study used a qualitative approach and exploratory design. A qualitative approach was chosen to gain insight into how individuals interpreted and attributed meaning to their experiences, behaviours and attitudes (Ahmed 2024; Merriam and Tisdell 2015). An exploratory study design was most suited because little is known about the phenomenon of parents' experiences of holding children for healthcare procedures (Rendle et al. 2019). The research was underpinned by the principles of Patient- and Family-Centred Care (PFCC), which is a theoretical framework that emphasises collaborative partnerships among healthcare providers, patients and families (IPFCC n.d.). Key components of PFCC include (1) dignity and respect, (2) information sharing and (3) participation and collaboration (IPFCC n.d.). The principles of PFCC are fundamental to paediatric clinical practice, recognising that a child's well-being is intrinsically linked to their family. Nurses operationalise PFCC by balancing competing considerations, enabling communication and advocating with empathy (O'Neill et al. 2023). To achieve genuine PFCC in the context of procedural management, an understanding of parental well-being and experience is necessary.

4.2 | Setting and Population

The population included parents of children who were admitted to a surgical, medical or specialty ward of a single centre tertiary paediatric hospital in Melbourne, Australia. To ensure a mix of procedural experiences was represented, three wards were selected where it was identified that children frequently underwent a range of healthcare procedures. Each selected ward had 30 beds and delivered care to children and young people from birth to 18 years for a range of medical and surgical conditions.

4.3 | Recruitment

A convenience sampling approach was used, followed by purposive sampling to intentionally select participants with specific characteristics (Merriam and Tisdell 2015), including parents with children of varying ages and procedural experiences. Parents who had a child receiving end-stage palliative care, acute mental health care, or who were identified by their primary healthcare team as vulnerable due to social circumstances

were excluded. As this study did not have the capacity to provide interpreters, parents who did not speak English were also excluded. Recruitment occurred from October to December 2022.

The principal researcher (S.H.) who is also a paediatric cardiology nurse, attended selected wards once a week over a 3-month period. Parents who met inclusion criteria were identified by S.H. liaising with the in-charge nurse. S.H. approached parents face-to-face, introduced herself and the study, and provided an information sheet detailing the study purpose, benefits and risks. A suitable time to undertake an interview was organised with those who consented to participate. The sample size for this study was assessed through an iterative process, with concurrent recruitment, data collection and data analysis occurring (Copnell and McKenna 2019). Parents were recruited until researchers determined that data saturation had been reached, and that no new relevant knowledge would be gained from additional interviews.

4.4 | Data Collection

Semi-structured interviews were conducted, with this data collection technique well suited to the research aim, which endeavoured to explore individual experiences (Braun and Clarke 2013). An interview guide was developed (Table 1) to allow researchers to ask questions that were consistent, but provided flexibility to change the order and wording of questions in response to parents' dialogue (Green and Thorogood 2018). To become familiar with this guide, a practice interview was completed with research team members prior to commencing data collection. Subsequently, further prompting questions were added.

Interviews were conducted by one of two researchers (S.H. or J.O.) and audio recorded for accurate transcription. These researchers were experienced in completing semi-structured interviews and were not involved in the care of the participating families. Prior to commencing each interview, the researcher confirmed consent given and revisited the purpose of the study. Following the interviews, field notes were documented. No repeat interviews were carried out during data collection.

Interview questions were centred around parents' experiences of holding and their interpretation of the child's procedural experience. Throughout interviews, the researcher used paraphrasing to ensure correct understanding of parents' responses in real time. In total, the research team comprised five advanced practice nurses (F.N., J.O., S.H., S.K., S.R.) and one non-clinical staff member (M.H.). At the time of the study, the collective training of the team included three PhD-trained researchers and one Master's-prepared researcher.

4.5 | Data Analysis

Data were analysed using six phases of reflexive thematic analysis, as detailed by Braun and Clarke (2022). An inductive approach was adopted during this process, with no attempt to fit the data into an existing theory or framework (Braun and Clarke 2022). In the first phase of analysis, researchers S.H. and J.O. became familiar with the dataset by closely reading full interview transcripts and making notes of initial ideas (Braun and Clarke 2022). The second phase involved analytic coding of the data, which occurred iteratively as the data were collected. During this phase, S.H. and J.O. systematically worked through datasets, adding labels to sections of text that appeared meaningful or relevant to the research question (Braun and Clarke 2022). To deepen reflexive engagement, several rounds of coding occurred with additional coders (F.N., M.H., S.K., S.R.) before all codes and relevant data extracts were collated.

In the third phase, S.H. and J.O. created potential themes by sorting codes and identifying broader patterns of meaning (Braun and Clarke 2022). This led to the fourth phase of analysis, where

TABLE 1 | Semi-structured interview guide.

Primary questions	Prompting questions
Tell me about your child's experience with healthcare procedures?	• What was the procedure? • Was the procedure planned or an emergency? • What went well/not so well?
How were you involved in the procedure?	• What did you see as your role in the procedure? • Did you or a healthcare professional hold your child during the procedure? • If yes, how was this decision made? • If you did not hold your child, what did you do instead of holding?
Tell me about your experience of your child being held for a procedure?	• Did you feel it was necessary that your child was held during the procedure? Why/why not? • What position was your child held during the procedure? • Do you think there were alternatives to holding at the time?
Have you ever had to stop a procedure or felt you had to advocate for your child during a procedure?	• Can you describe this?
What were the short-term and/or long-term consequences of your child's procedural experience?	• Can you describe this?

themes were further refined. S.H. and J.O. checked potential themes against the coded data and original transcripts and then presented themes back to the broader team with supporting quotes. Regular investigator meetings were held, where members challenged interpretations and engaged in reflexive discussion. This ensured themes accurately told a story of the data and addressed the research question. During these meetings, redundant themes were discarded, and repetitive themes were collapsed.

The fifth phase was refining, defining and naming themes (Braun and Clarke 2022), where the team collaboratively decided on an informative name for each theme and subtheme. Evidence of how initial codes, subthemes and themes were derived from the data is available in Supporting Information 1. The final phase of analysis was writing up findings (Braun and Clarke 2022), where rich quotes from participating parents supported the story of data being told.

4.6 | Ethical Considerations

Ethical approval was granted from The Royal Children's Hospital Human Research Ethics Committee with the registration HREC/85891/RCHM-2022, 29/08/2022. Parents were informed prior to recruitment that their decision to participate would not impact their child's care and that they could terminate their interview at any time. No parents chose to terminate their interview.

4.7 | Rigour

Trustworthiness of data was achieved through dependability, confirmability, transferability and credibility (Lincoln and Guba 1986). Dependability and confirmability were enhanced by thorough explanation of the research procedure, including the data analysis process and a rigorous audit trail detailing researchers' discussions (Ahmed 2024). Thick descriptions of contextual information including the study setting, sampling approach and participants, enhanced transferability of findings (Lincoln and Guba 1986). Credibility was promoted by (1) adhering to a systematic and ethically supported method of data collection and analysis, (2) regular investigator meetings and group discussions throughout the analysis process, (3) staying close to the data by checking codes and themes against original transcripts and (4) considering researchers' reflexivity.

4.8 | Reflexivity

It was important for researchers to acknowledge personal biases that could have inherently impacted data collection, analysis and interpretation of findings (Ahmed 2024). Considering the value of the 'insider' perspective provided balance to the researchers' reflexivity and positionality. The six research team members identified as female and had differing personal roles that may have influenced their perspective and understanding of the research context. Four team members were parents, with children of various ages. These members had previously interacted with paediatric healthcare services as a parent. Five members of the team were also registered nurses. S.H. actively worked in a paediatric cardiology outpatient clinic, regularly interacting with parents and F.N., J.O., S.K. and S.R. had transitioned away from clinical-facing roles; however, had extensive experience in paediatric haematology, neurodevelopmental medicine, intensive care and surgical care settings. The sixth member (M.H.) provided non-clinical expertise to the team, and helped challenge assumptions during data analysis, that may have been influenced by others' prior clinical experience. All members acknowledged that they had an interest in pursuing the research topic, as they had previously witnessed distressed children being held for healthcare procedures in either a professional or personal capacity.

5 | Findings

5.1 | Participants

As part of this study, 11 parents consented to participate; three parents withdrew from the study prior to interviewing for reasons including their child's health deteriorating, or conflicting work and family commitments. Eight parents were interviewed, including seven who identified as a mother and one who identified as a father. Five of these interviews were completed face-to-face on a hospital ward, and three interviews were completed via telephone, with the duration of interviews ranging from 12 to 40 min (mean 19 min). On two occasions, at a parents' request, a young child (under 4 years) was present whilst a face-to-face interview took place. Two parents spoke a second language at home. Children of participants had been admitted to hospital for various medical and surgical reasons, including respiratory illnesses, renal conditions, cardiac surgery and trauma injuries. Half the parents who were interviewed had children who experienced greater than 20 healthcare procedures during their lifetime, highlighting a repeated exposure to procedures. Table 2 details characteristics of each parent and their child, using pseudonym names chosen by the research team.

To provide greater context of the study, the procedures children underwent and physical holding described by parents are detailed in Table 3.

5.2 | Themes

Key findings from understanding parents' experiences, highlighted parents undertook multiple roles when holding their child for a healthcare procedure. As shown in Figure 1, these roles included being a *protector*, *comforter*, *helper* and *enforcer*, with the latter three roles positioned along a continuum, with parents often moving between these roles throughout a procedure. Each role was accompanied by subthemes that included communicating the child's needs, feeling what the child was feeling, providing reassurance, being present, seeking a role, stepping up and just having to get it done.

5.3 | Parent as a Protector

Protection became the overarching theme of the study, as all roles involved aspects of parents protecting their child. This

TABLE 2 | Characteristics of parents and their child.

Interview	Parent's pseudonym	Child's pseudonym	Child's age range in years	Number of procedures in child's lifetime	Type of admission
1	Lin	Zhen	1–4	6–10	Medical
2	Pam	Alex	> 12	11–20	Surgical
3	Gillian	Mitch	1–4	> 20	Medical
4	John	Beau	1–4	> 20	Medical
5	Sarah	Zoe	5–11	11–20	Surgical
6	Mariet	Hazel	< 1	> 20	Surgical
7	Jess	Zac	< 1	> 20	Surgical
8	Nat	Ethan	5–11	6–10	Medical

TABLE 3 | Healthcare procedure and parents' description of how they held their child.

Healthcare procedure	Parents' holding description
Finger prick blood test	Parent held child's arms
Anaesthetic mask induction	Parent held child's hands
Subcutaneous injection	Parent held child's upper body, in a 'hug type' hold
Line removal	Parent sat on bed, with child laying on parent's chest
Venipuncture blood test	Parent gave child 'gentle hug' whilst child sat on parent's lap
Urine catheter insertion	Parent held child's arm
Feeding tube insertion	Parent held child's head 'steady'
Feeding tube insertion	Parent held child's hands and feet
Intramuscular injection	Parent held child's arms

was particularly apparent through parents *Communicating their child's needs*, with parents advocating to give their child time, choice and involvement in decision-making. Gillian (Interview 3), mother of Mitch, emphasised 'I feel like I must advocate for him. I guess it's giving that voice, because he can't say it himself yet, like what he might prefer and how it might work better for him'.

Most parents highlighted the importance of telling their child the truth, with some also describing speaking up or saying stop if necessary, during a procedure. Mariet (Interview 6), mother of Hazel, voiced 'it's a scale of getting to know your child and how they respond or cry, and then just putting your foot down and saying, no, this is something wrong, don't do that'.

Experiences from parents suggested they were also *Feeling what the child was feeling*. Lin (Interview 1), mother of Zhen, expressed 'he was crying, and I was crying, but I still had to hold him'. Lin's comment emphasised that parents' emotions were closely influenced by their child's experience. Many parents acknowledged difficulties of the situation for their child, and their own personal and emotional challenges. Nat (Interview 8), mother of Ethan, explained:

> That was the moment I lost my ability to hold back emotions... I knew holding was necessary, but yeah, it was really challenging. Umm and yeah. I just. I pretty much cried for 12-hours straight, when he [Ethan] wasn't looking and when he was asleep.

5.4 | Parent as a Comforter

Collectively, parents expressed how challenging procedures were for their child, with *Providing reassurance* reflecting how they offered comfort. Parents suggested being positive for their child was important, this was demonstrated through the verbal reassurance they provided to their child throughout a procedure. Additionally, physical reassurance was reflected by parents holding their child to feel safe and comfortable. John (Interview 4), father of Beau, articulated that his role as a parent was 'to make him [Beau] feel comfortable, to make him feel safe, to make him feel okay with what was going on'.

Despite being emotionally challenging, parents *Being present* was thought to be helpful. There was consensus among parents that their presence during a procedure alleviated some of their child's stress and anxiety. Mariet (Interview 6), mother of Hazel, explained 'you don't like hearing them in distress or discomfort, but you know they're actually taking it better with mum and dad being there'. Although, notably, for some procedures not every parent felt they could be present to comfort their child, with Pam (Interview 2), mother of Alex, acknowledging her own coping abilities 'I had the option to leave and I'm glad I did, because I don't think I would have coped watching him go through that'.

Most parents, however, placed an importance on always being present during procedures, as Jess (Interview 7), mother of Zac,

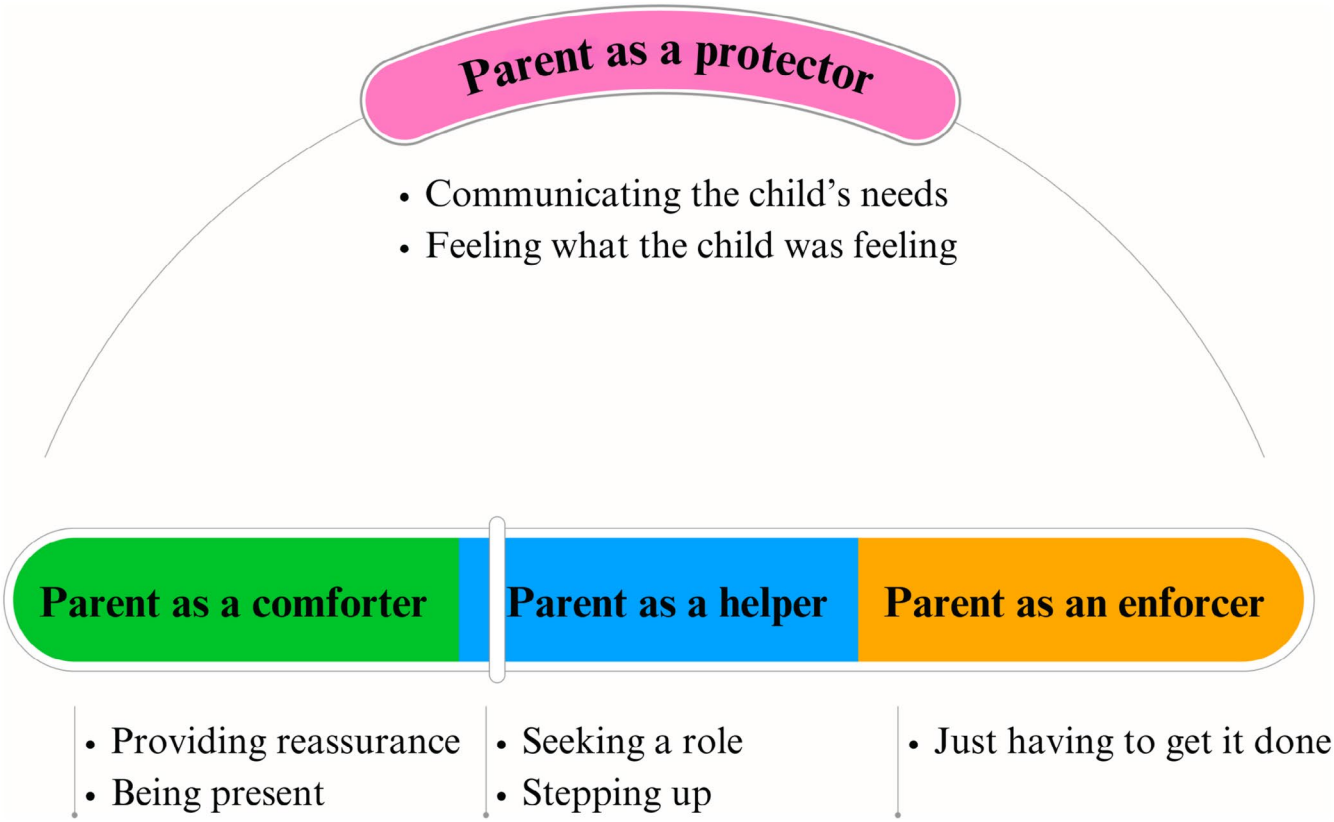

FIGURE 1 | Parental roles when holding a child during healthcare procedures.

explained 'I've always been present. I've always been there, for every one of them [procedures] and helped hold his hands if he's kicking or fussing, or holding his feet, you know, being a comfort to him'.

5.5 | Parent as a Helper

The helper role was portrayed by parents *Stepping up* when they saw there was a need to help hold during a procedure, as Sarah (Interview 5), mother of Zoe, did 'I was given the option of having another nurse come in, if I didn't want to hold her. But I said that I was okay to hold her down'. Parents also stepped up on some occasions when there were no other healthcare staff available to assist. Mariet (Interview 6), mother of Hazel shared:

> I've been asked [during a heel prick blood test] 'can you please help hold bub still, it makes it so much easier', and then you're like, 'yeah'... You feel a bit like well, there is nobody else around, so you kind of have to step in.

Some parents were *Seeking a role* or wanting to feel useful during a procedure, and actively sought guidance on how they could do this. Sarah (Interview 5), mother of Zoe, explained how she 'put [positioned] myself in a way, and then I said, is this okay? Let me know if you need me to do anything. And they [the nurses] said what I was doing was fine'. Parents who described helper roles during procedures, benefitted most when that role was clearly defined and supported by healthcare staff. Gillian (Interview 3), mother of Mitch, highlighted this support when she explained her experience of a nurse suggesting that she sat behind Mitch and helped hold him:

> I feel like you have to be prompted, because you just don't think of it...Sometimes you feel like you're in the way, it's actually when you're sitting on the bed holding, that you don't feel like you're in the way.

5.6 | Parent as an Enforcer

At times parents felt it was necessary to hold their child for a procedure, which was represented by *Just having to get it done*. Parents felt holding their child was sometimes needed to prevent further discomfort, particularly for procedures that required precision, such as inserting a feeding tube. Mariet (Interview 6), mother of Hazel, explained 'it's uncomfortable and if she's swinging her head from side to side. That movement can disrupt it [feeding tube] and make it more uncomfortable. So sometimes holding is necessary'.

Similarly, some parents deemed holding necessary when a procedure was considered urgent, which occasionally led to unintentional forceful holding. Nat (Interview 8), mother of Ethan, acknowledged:

> I understood why they needed to get it in, as he had significant kidney health readings. They needed to

> be seeing straight away what was coming out of his bladder... But they had a bit of trouble getting it in, so we did have a lot of holding during that procedure. We had one nurse holding legs, me on one arm, and another nurse on the other arm.

When parents reflected on previous procedures, sometimes completing procedures quickly and efficiently was considered necessary, particularly, when a procedure was thought to be non-negotiable. Pam (Interview 2) explained an instance when she held her, now teenage son Alex, still for a general anaesthetic as a young child: 'I thought, well this is what we've got to do, to get it done. And we had to get it done, there was no choice, so let's just do it'.

6 | Discussion

This exploratory qualitative study interviewed eight parents to explore their experiences of holding their child for a healthcare procedure. Parents' involvement in procedures was exemplified through the multiple roles they undertook, with parent as a *protector* the overarching role, as all roles identified within this study—*comforter*, *helper* and *enforcer*—involved aspects of parents protecting their child. A novel finding from this study was making the roles parents take on during a procedure explicit, furthermore, these roles were not static but rather positioned along a continuum, with parents moving between roles throughout a procedure. This continuum of roles became apparent through parents' advocacy for their child, desire to promote comfort, ability to help or assist when needed and belief that to facilitate some procedures holding was necessary. Recognising that parent roles are not static is important for clinicians, as this understanding highlights the complexity of roles parents often move between during a procedure.

At the forefront of the findings was parents' instinctive need to protect their child, demonstrated through the overarching 'parent as a protector' role. The concept of parent protectors has been previously described in qualitative research, with Brenner (2013) and Svendsen et al. (2018) also suggesting parents have an innate desire to protect their child from unnecessary suffering during procedures. Building upon previous research, the current study explored in greater detail the numerous ways parents actualise their protector role. It was recognised that whilst parents' overarching protector role remained constant, the additional roles changed according to the context of the procedure. Roles were influenced by parents' perception of how their child was coping, whether the procedure was deemed urgent, or if the parent thought getting the procedure done quickly would be in the best interests of their child.

In this study, parents reported being present was important and comforting for their child; on occasion, their presence was thought to alleviate some of their child's stress and anxiety. These findings are similar to those from Salmela et al. (2010) who suggested parental presence was a coping strategy that helped children manage their hospital related anxiety and fears. Snyder (2004) further emphasised the importance of parental presence by reporting parents have an ability to provide verbal and physical reassurance, which was also consistent with findings from the current study. Alongside their presence, parents' desire to provide comfort and reassurance often evolved into wanting to help with the procedures in some way, which saw parents holding their child in a helper role.

Parents described procedures where they were actively seeking a role and times when they were asked to assist. In instances where parents were helping during a procedure, findings suggested parents benefitted most when their role was clearly defined and supported by healthcare staff. This aligns with Cavender et al. (2004) who suggest that clear identification of roles can augment the potential benefit of parental presence. When establishing which role parents would like to take on, it is important to distinguish between a comforting and helping role, as not all parents feel they can help or assist during a procedure. A qualitative study by McGrath and Huff (2003), which explored parents' experiences of their child's oncology treatments, reported that parents found witnessing and being involved in procedures, including holding their child, distressing. Clinicians can define with parents which role along the continuum they would feel most comfortable taking on. This is supported by Svendsen et al. (2018) who emphasised parents should be involved in the planning of procedures when holding is likely to occur. The sliding-scale schema (see Figure 1) developed through the current study, which illustrates the parent roles, can be used by clinicians as a practical visual tool during procedural planning, particularly to promote parental involvement. The visual tool can be integrated into procedural planning discussions to help clinicians and parents establish which role the parent would be best suited to take on during their child's procedure.

Findings from this study also suggest some parents can assume an enforcer role, particularly for procedures that require the child to remain still for their safety, such as feeding tube insertion, and the safety of others, such as needle-related procedures. Additionally, Snyder (2004) claimed that parents setting limits on a child's behaviour, can act as a psychological intervention when children are resisting treatments or procedures. However, as demonstrated through parents' quotes in this study, in some situations, there is potential for forceful holding to unintentionally occur. Bray et al. (2015) suggests that parents' decision to hold their child—to 'just get the procedure done'—can lead to an unpleasant and distressing experience for the child. It is also well established that forceful holding, during a healthcare procedure, can have negative consequences, including physical and emotional distress for both parents and children (Bray et al. 2015; Brenner, Drennan, et al. 2014; Kirwan and Coyne 2017; McGrath et al. 2002). Therefore, it is important to recognise when a parent is in an enforcer role; to support them to apply minimal force and decrease any unnecessary holding. It may even be necessary to identify a different role, along the proposed continuum, for parents to take on within the procedure. Additionally, given the emotional impact holding children can have on parents (McGrath et al. 2002), it is important that parents are provided with an opportunity to debrief with healthcare staff after the procedure is completed (Brenner 2013). Through debriefing, parents can reflect on their role during the procedure and consider any changes that

could be implemented to help improve future healthcare procedures for their child.

The implications of this study for practice include an increased awareness of parent roles. This awareness can support clinicians working with parents in clinical settings to navigate their role effectively. This is particularly true if parents are struggling to identify a role to take on where they can best support their child for a healthcare procedure. Active support such as this, along with a flexible response and balancing competing considerations, emphasises the functional approach nurses can take to promote PFCC outcomes (O'Neill et al. 2023). The study findings can further be used to enhance paediatric procedural management by informing nursing guidelines, staff education and the information provided to families before procedures. For instance, the findings highlight the benefits of parental presence during procedures and emphasise the importance of discussing the comforter or helper roles that parents can play.

6.1 | Strengths and Limitations

The range of parents, with children of varying ages and procedural experiences, was a strength of the study. This variety enabled in-depth exploration of parents' experiences with both young and older children, which was considered important, as a child's age can influence the decision to hold them for a healthcare procedure. Despite inviting both mothers and fathers to participate in this study, only one father was recruited, reflecting challenges faced in identifying fathers available to participate. This limited exploration of potential gender-related differences in experiences and responses. The small sample size was also a limitation for consideration; however, it was consistent with the qualitative research approach and still allowed a rich understanding of parents' experiences to be gained. This study was completed at a single centre, focusing solely on parents' whose child was admitted to an inpatient ward. Consequently, parents' perspectives and information they considered important, may have been influenced by their child's current hospital admission. Furthermore, this study was only accessible to parents who spoke English. Therefore, it is necessary to acknowledge that holding experiences may differ for parents who are from linguistically diverse backgrounds.

6.2 | Recommendations for Future Research

Parents' perceptions of procedural experiences are reported throughout the current study; however, the voices of children and young people remain underrepresented in research, particularly relating to the phenomenon of being held for a healthcare procedure. Therefore, to inform a broader understanding of procedural management and the impact holding has on all individuals involved in a procedure, experiences and perceptions of children and young people should be explored. As this study was not able to engage with parents and caregivers who had a non-English language preference and recruited only one father, future research should seek to prioritise strategies to include these participant groups to gain their valuable perspectives about the practices of holding children for healthcare procedures.

7 | Conclusion

This study highlighted that parents take on an overarching protector role during healthcare procedures. Parents are sometimes balancing a desire for their child to feel safe, holding as a comforter, with wanting to get the procedure done, and therefore holding as an enforcer. It was recognised that parents can move between roles during a procedure. These findings call for the inclusion of parents in healthcare procedures, with consideration for identifying, encouraging and supporting the roles they take on.

Author Contributions

All authors have agreed on the final version and meet at least one of the following criteria: (1) Substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data. (2) Drafting the article or revising it critically for important intellectual content. **S.H.:** conceptualisation, methodology, investigation, project administration, formal analysis, visualisation, writing – original draft, writing – review and editing. **S.K., S.R., F.N.:** conceptualisation, methodology, formal analysis, mentorship, writing – review and editing. **M.H.:** formal analysis and writing – review and editing. **J.O.:** conceptualisation, methodology, investigation, formal analysis, mentorship, writing – review and editing.

Acknowledgements

The authors would like to thank the parents who participated in this study for generously giving their time and sharing their experiences with such honesty. They also acknowledge the Donald Ratcliffe and Phyllis MacLeod Trust and The Royal Children's Hospital Foundation for supporting Nursing Research at The Royal Children's Hospital. Open access publishing facilitated by The University of Melbourne, as part of the Wiley - The University of Melbourne agreement via the Council of Australian University Librarians.

Ethics Statement

Ethical approval was granted from The Royal Children's Hospital Human Research Ethics Committee with the registration HREC/85891/RCHM-2022, 29/08/2022.

Consent

Written informed consent was obtained from all individual participants included in the study.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The authors have nothing to report.

References

Ahmed, S. K. 2024. "The Pillars of Trustworthiness in Qualitative Research." *Journal of Medicine, Surgery, and Public Health* 2: 1–4. https://doi.org/10.1016/j.glmedi.2024.100051.

Braun, V., and V. Clarke. 2013. *Successful Qualitative Research: A Practical Guide for Beginners*. Sage.

Braun, V., and V. Clarke. 2022. *Thematic Analysis: A Practical Guide*. Sage.

Bray, L., B. Carter, and J. Snodin. 2015. "Holding Children for Clinical Procedures: Perseverance in Spite of or Persevering to Be Child-Centered." *Research in Nursing and Health* 39, no. 1: 30–41. https://doi.org/10.1002/nur.21700.

Bray, L., B. Carter, L. Blake, K. Ford, A. Dickinson, and T. Water. 2018. "Holding Children for Procedures: An International Survey of Health Professionals." *Journal of Child Health Care* 22, no. 2: 205–215. https://doi.org/10.1177/1367493517752499.

Breiner, H., M. A. Ford, V. L. Gadsden, and National Academies of Sciences, Engineering, and Medicine (U.S.). Committee on Supporting the Parents of Young Children, issuing body. 2016. *Parenting Matters: Supporting Parents of Children Ages 0–8*. National Academies Press.

Brenner, M. 2013. "A Need to Protect: Parents' Experiences of the Practice of Restricting a Child for a Clinical Procedure in Hospital." *Comprehensive Child and Adolescent Nursing* 36, no. 1–2: 5–16. https://doi.org/10.3109/01460862.2013.768312.

Brenner, M., J. Drennan, M. P. Treacy, and G. Fealy. 2014. "An Exploration of the Practice of Restricting a Child's Movement in Hospital: A Factorial Survey." *Journal of Clinical Nursing* 24, no. 9–10: 1189–1198. https://doi.org/10.1111/jocn.12650.

Brenner, M., M. P. Treacy, G. Fealy, and J. Drennan. 2014. "Nurses' Perceptions of the Practice of Restricting a Child for a Clinical Procedure." *Qualitative Health Research* 24, no. 8: 1080–1089. https://doi.org/10.1177/1049732314541332.

Cavender, K., M. D. Goff, E. C. Hollon, and C. E. Guzzetta. 2004. "Parents' Positioning and Distracting Children During Venipuncture: Effects on Children's Pain, Fear, and Distress." *Journal of Holistic Nursing* 22, no. 1: 32–56. https://doi.org/10.1177/0898010104263306.

Copnell, B., and L. McKenna. 2019. *Fundamentals of Nursing and Midwifery Research: A Practical Guide for Evidence-Based Practice*. Allen & Unwin.

Coyne, I., and P. Scott. 2014. "Alternatives to Restraining Children for Clinical Procedures." *Nursing Children and Young People* 26, no. 2: 22–27. https://doi.org/10.7748/ncyp2014.03.26.2.22.e403.

Crellin, D., F. E. Babl, T. P. Sullivan, J. Cheng, R. O'Sullivan, and A. Hutchinson. 2011. "Procedural Restraint Use in Preverbal and Early-Verbal Children." *Pediatric Emergency Care* 27, no. 7: 622–627. https://doi.org/10.1097/PEC.0b013e31822255b6.

da Silva, R. A., R. S. Tordivelli, M. A. de Garcia Avila, et al. 2024. "Holding and Restraining Children for Clinical Procedures: A Scoping Review of Health Professional Reported and Observed Practice." *Journal of Child Health Care*: 1–20. https://doi.org/10.1177/13674935241248677.

Graham, P., and M. Hardy. 2004. "The Immobilisation and Restraint of Paediatric Patients During Plain Film Radiographic Examinations." *Radiography* 10, no. 1: 23–31. https://doi.org/10.1016/j.radi.2004.01.002.

Green, J., and N. Thorogood. 2018. *Qualitative Methods for Health Research*. 4th ed. Sage.

Homer, R., and S. Bass. 2010. "Physically Restraining Children for Induction of General Anesthesia: Survey of Consultant Pediatric Anesthetists." *Pediatric Anesthesia* 20, no. 7: 585–679. https://doi.org/10.1111/j.1460-9592.2010.03324.x.

Institute for Patient- and Family-Centered Care. n.d. *Patient and Family Centred Care*. IPFCC. https://www.ipfcc.org/about/pfcc.html.

Jeffery, K. 2010. "Supportive Holding or Restraint: Terminology and Practice." *Paediatric Nursing* 22, no. 6: 24–28. https://doi.org/10.7748/paed2010.07.22.6.24.c7841.

Kirwan, L., and I. Coyne. 2017. "Use of Restraint With Hospitalized Children: A Survey of Nurses' Perceptions of Practices." *Journal of Child Health Care* 21, no. 1: 46–54. https://doi.org/10.1177/1367493516666730.

Lambrenos, K., and E. McArthur. 2003. "Introducing a Clinical Holding Policy." *Paediatric Nursing* 15, no. 4: 30–33. https://doi.org/10.7748/paed2003.05.15.4.30.c852.

Lincoln, Y. S., and E. G. Guba. 1986. "But Is It Rigorous? Trustworthiness and Authenticity in Naturalistic Evaluation." *New Directions for Program Evaluation* 1986, no. 30: 73–84. https://doi.org/10.1002/ev.1427.

Lombart, B., C. de Stefano, D. Dupont, L. Nadji, and M. Galinski. 2020. "Caregivers Blinded by the Care: A Qualitative Study of Physical Restraint in Pediatric Care." *Nursing Ethics* 27, no. 1: 230–246. https://doi.org/10.1177/0969733019833128.

McGrath, P., and N. Huff. 2003. "Including the Fathers' Perspective in Holistic Care. Part 2: Findings on the Fathers' Hospital Experience Including Restraining the Child Patient for Treatment." *Australian Journal of Holistic Nursing* 10, no. 2: 5–10.

McGrath, P., K. Forrester, S. Fox-Young, and N. Huff. 2002. "'Holding the Child Down' for Treatment in Paediatric Haematology: The Ethical, Legal and Practice Implications." *Journal of Law and Medicine* 10, no. 1: 84–96.

Merriam, S. B., and E. J. Tisdell. 2015. *Qualitative Research: A Guide to Design and Implementation*. 4th ed. John Wiley & Sons.

Ng, J. H. S., and E. Doyle. 2019. "Keeping Children Still in Medical Imaging Examinations- Immobilisation or Restraint: A Literature Review." *Journal of Medical Imaging and Radiation Sciences* 50, no. 1: 179–187. https://doi.org/10.1016/j.jmir.2018.09.008.

O'Neill, J., B. Devsam, S. Kinney, M. Hawley, S. Richards, and F. Newall. 2023. "Exploring the Impact of the COVID-19 Environment on Nursing Delivery of Family-Centred Care in a Paediatric Hospital." *Journal of Advanced Nursing* 79, no. 1: 320–331. https://doi.org/10.1111/jan.15469.

Østberg, M. K., P. F. Hougaard, N. M. Kynø, and E. J. Svendsen. 2024. "The Use and Prevention of Procedural Restraint in Children—A Scoping Review." *Journal of Pediatric Nursing* 79: e110–e118. https://doi.org/10.1016/j.pedn.2024.10.006.

Page, A., and A. A. McDonnell. 2015. "Holding Children and Young People: Identifying a Theory-Practice Gap." *British Journal of Nursing* 24, no. 8: 447–451. https://doi.org/10.12968/bjon.2015.24.8.447.

Rendle, K. A., C. M. Abramson, S. B. Garrett, M. C. Halley, and D. Dohan. 2019. "Beyond Exploratory: A Tailored Framework for Designing and Assessing Qualitative Health Research." *BMJ Open* 9: e030123. https://doi.org/10.1136/bmjopen-2019-030123.

Salmela, M., S. Salanterä, and E. T. Aronen. 2010. "Coping With Hospital-Related Fears: Experiences of Pre-School-Aged Children." *Journal of Advanced Nursing* 66, no. 6: 1222–1231. https://doi.org/10.1111/j.1365-2648.2010.05287.x.

Snyder, B. S. 2004. "Preventing Treatment Interference: Nurses' and Parents' Intervention Strategies." *Pediatric Nursing* 30, no. 1: 31–40.

Svendsen, E. J., A. Moen, I. T. Bjørk, and R. Pedersen. 2017. "Exploring perspectives on restraint during medical procedures in paediatric care: A qualitative interview study with nurses and physicians." *International Journal of Qualitative Studies on Health and Well-being* 12, no. 1: 1–11. https://doi.org/10.1080/17482631.2017.1363623.

Svendsen, E. J., A. Moen, I. T. Bjørk, and R. Pedersen. 2018. "'But Perhaps They Could Reduce the Suffering?' Parents' Ambivalence Toward Participating in Forced Peripheral Vein Cannulation Performed on Their Preschool-Aged Children." *Journal of Pediatric Nursing* 41: e46–e51. https://doi.org/10.1016/j.pedn.2018.03.004.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.