

NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER
NURSING and PATIENT CARE SERVICES

PROCEDURE: Child Safety Hold and Transport

Approved:

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Formulated: 9/99
Implemented: 11/99
Revised: 9/01, 10/03

PROCEDURE: CHILD SAFETY HOLD AND TRANSPORT

I:/shared governance/documents/pro/child safety hold transport

I. ESSENTIAL INFORMATION

- Safety holds are a type of physical restraint.
- The goal of safe holding is the behavioral control, care, and treatment of the out-of-control child.
- Child is defined as a person significantly smaller and less strong than the staff member.
- All less restrictive interventions are attempted before utilizing physical containment holds.
- Fear most often generates out-of-control behavior in children, e.g., fear of being hurt during medical procedures.
- Safety holds are designed to be used for brief periods, and may be a less restrictive method of restraint used before considering the need for a more restrictive (papoose) child restraint device.
- Definitions and guidelines relevant to restraints are contained within the Medical Administrative Series Policy MAS M94-10 (rev. September 04, 2003), Subject: Restraint and Seclusion.
- Prevention of and use of least restrictive methods to prevent or contain aggressive behavior are addressed in the Nursing Department Standards of Practice: Nursing Prevention and Management of Aggressive Behavior (formulated 1/94, implemented 10/94, revised 8/95, 9/97, 11/98, 12/99, 10/03)
- Satisfactory completion of the CCND competency program for the child safety hold and transport is required to utilize this procedure.
- Documentation includes MIS documentation as well as NIH 2797: Seclusion and Restraint Posting Form Behavioral Health Setting

II.

STEPS

1. Analysis of the situation.
2. Formulate plan from the results of the analysis
 - a. determine goals of intervention
 - b. team leader organizes staff interventionIf circumstances do not allow for pre-planning the intervention, the staff member initially involved in the emergency calls for help.
3. Preparation
 - a. self
 1. psychological (gathering control over own emotions and feelings)
 2. physical (removing jewelry, pens from pockets, neck ties, eye wear, etc.)
 - b. environment
 1. remove other patients from the area, move chairs, etc.
 - c. final instructions to team members
4. Inform child of procedure. Utilize simple concrete statements to elicit child's cooperation.
5. Staff gains control of child's arms and

KEY POINTS

1. In order to make a statement about the behavioral possibilities for the child in the very immediate future.
2.
 - b. Team leader may be the first person on the scene, the person who knows the child best, or most knowledgeable and confident person. Optimal team is at least two staff.
4. Knowing what to expect may lower the child's anxiety and enhance cooperation. Use of concrete, age-appropriate language helps child to understand directions while distressed.
5. Avoid application of force to joints.

- positions self to secure child.
6. To secure child's arms, staff locks child's arms one under the other across the child's chest. Staff is positioned behind, with hip slightly turned in towards child's back. *See drawing at end of procedure.* Staff member turns own head to side, reducing potential strike. Move as the child moves, not resisting their momentum.
 7. Move in the direction of the child's movement to simultaneously contain and comfort the child.
Second staff member must observe child's face, continually monitoring for any sign of physiologic distress.
 8. Hold maintained until child regains control.
 9. If child does not regain control in reasonable time, plan and implement alternative intervention. Notify clinically and administratively responsible parties.
 10. Transport to more secure environment may be required. Two staff walk the child using the upright transport method. *See drawing at end of procedure.*
 11. Transport to secured area.
 12. Involved staff review the procedure immediately following the intervention.
6. The hold is maintained by positioning the child's arms so that elbows are locked in position. Use arm/elbow positioning to secure the hold rather than grasping the arms too tightly. Minimize pressure to ribcage and diaphragm, avoiding trachea area. Avoid pressure to long bone joints.
 7. Moving in the direction of the child's motion while maintaining the control hold allows for gradual and comforting energy release. In addition, less force is necessary to maintain control position. Potential injury to child is avoided.
Constant monitoring of child's face prevents occurrence of physiologic distress, especially any potential for airway obstruction.
 8. Behavioral health units may need to utilize papoose board, seclusion, or locked leather restraints (over the age of 12 only). These most restrictive interventions are to be minimized: clarify the child's need underlying the behavioral disruption and address those needs via care planning and delivery. Non-behavioral health units may call for psychiatric nursing or medical consultation.
 10. At least one staff member is standing by in a support position. Injury is more likely if staff bodily carries the child. Steps of the upright transport methods are described in CCND Procedure: Physical Intervention with an Aggressive Patient.
 11. At least one staff member, preferably two, assist with the upright, walking transfer. Loosening of security is more apt to occur during transitions in position and direction.
 12. Critical review session provides opportunity to evaluate efficacy of intervention and for professional expression of feelings evoked by aggressive behavior. The intervention team identifies factors contributing to child's immediate and ongoing loss of control, and incorporates this preventative

assessment into the care planning process.

DOCUMENTATION

Document in electronic record interdisciplinary notes assessment, intervention, and outcome including:

1. Child's behaviors precipitating the need for safety holding;
2. Less restrictive interventions which were unsuccessful in helping the child re-establish self-control.
3. Extent to which child was able to cooperate with the procedure;
4. Specific interventions utilized and child's response:
 - Use of child safety hold/transport per Nursing Department procedure
 - Date, time, and duration of hold procedure
 - Names of staff involved in procedure
 - Child's response to intervention
 - Readily observed physical condition of the child
 - Any injury to child or others
5. Specifics of communication with clinically and administratively responsible parties when safety hold proves inadequate to maintain child's safety;
6. Notification of child's parent/guardian.

Complete NIH-2797 Seclusion and Restraint Posting Form Behavioral Health Setting
Report use of ANY hands-on intervention.

References

1. CCND Standard of Practice: Nursing Prevention and Management of Aggressive Behavior (formulated and implemented 1994, revised 1995, 1997, 1998, 1999, 2003)
2. CCND Procedure: Nursing Intervention with an Aggressive Patient (formulated 1994, revised 1995, 1997, 1998, 1999, 2000, 2003)
3. CCND Procedure: Papoose Restraint Application in Behavioral Health Settings (formulated 1995, implemented 1996, revised 1997, 1998, 1999, 2000, 2003)
4. Crisis Prevention Institute: Nonviolent Crisis Intervention Training Program. 2002. Brookfield, WI
5. Clinical Center Policy and Communications Bulletin: Restraint and Seclusion, Medical Administrative Series, M 94-10 (revised 04 September 2003).
6. Title 10; Department of Health and Mental Hygiene, Subtitle 21 Mental Health Regulations; General Article 10-21-12; Annotated Code of Maryland; Maryland Register Volume 19, Issue 22, Friday, October 30, 1992

