

other children' and many were adept at negotiating risks and benefits in order to 'fit in'. Chronic illness – to a greater or lesser extent – was 'always there' but it was often successfully backgrounded through careful planning. The children actively foregrounded their achievements and focused on 'getting on' with being a child. This was not always easy. Whilst there was evidence of much resilience, this took effort and imagination from the children and their families. The children's parents/carers provided an important role in supporting the children's ability to self-manage their illness.

**Conclusion** Brokering and self-management were evident in the stories children told about themselves. The use of photo-elicitation gave the children control over those facets of their lives they wanted to discuss and share with the researchers. We found it a useful tool to discover those things that were important to the children and how they were active in ensuring that they could say 'I can.....'

### G235 HOLDING CHILDREN FOR CLINICAL PROCEDURES; AN ETHICAL CONSIDERATION OF THE EVIDENCE

<sup>1,2</sup>L Bray, <sup>2,3</sup>B Carter, <sup>4</sup>J Snodin. <sup>1</sup>Evidence-Based Practice Research Centre, Edge Hill University, Ormskirk, UK; <sup>2</sup>Children's Nursing Research Unit, Alder Hey Children's NHS Foundation Trust, Liverpool, UK; <sup>3</sup>School of Health, University of Central Lancashire, Preston, UK; <sup>4</sup>Faculty of Health and Social Care, Edge Hill University, Ormskirk, UK

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**Aim** This presentation will review current evidence on clinical holding and discuss how holding children, for clinical procedures against their wishes, can create tension between children's rights and agency and health professionals' duty to care and to act in the best interests of children in their care.

**Method** A narrative synthesis approach used systematic procedures to search and appraise the current empirical evidence relating to children being held for procedures within an acute children's care setting. Children in mental health, dental, primary care and anaesthetic settings were excluded from the review.

**Findings** Empirical evidence demonstrates that children are frequently held for procedures to be completed within acute care settings. The delineation between holding and restraint is poorly defined. Children's protests and distress are reported as taking lower precedence in a decision to hold a child for a procedure than either clinical need or the interests of the adults present. Parents and health professionals expressed feelings of distress, uncertainty, guilt and upset associated with clinical holding. Despite this, alternatives to holding are not always explored and health professionals maintain that the child's best interests are served by a procedure being completed quickly at the expense of short-term distress; the end justifying the means. This approach neither takes into consideration the possible long-term psychological consequences of holding or restraining children for non-urgent procedures nor how their rights and agency are protected by the adults charged with advocating for them. Evidence suggests that current practice is weighted towards an adult centred approach and that consideration needs to be given to how practice can be tipped towards a child centred approach.

**Conclusion** Although children are reported as being frequently held for clinical procedures, there is very little quality empirical data or critical ethical debate to inform practice. The lack of robust evidence and clear definitions of what constitutes holding perpetuate this being an almost invisible and taken for granted part of children's care within acute settings.

### G236 BRIDGING THE GAP; FROM FAMILY CENTRED CARE TO FAMILY – ENABLED CARE?

P Curtis, A Northcott, J Reid. *School of Nursing and Midwifery, University of Sheffield, Sheffield, UK; Sheffield Children's NHS Foundation Trust, Sheffield, UK*

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**Aims** The concept of family centred care (FCC) has informed the provision of care to hospitalised children since the late 1980s. However, there is a well acknowledged gap between the principles and practice of FCC. Differences between the expectations of care providers have been demonstrated as has nurses' reticence to share decision-making and cede control to family members. Family members, in turn, have pointed to the lack of support received from nurses. This paper presents findings from a study which sought to explore the potential for care contracts to support family – enabled hospital care for children.

**Methods** A 10 month, focused ethnographic study was carried out in 2 medical and 2 surgical wards in one Children's Hospital in the North of England. Data, focusing upon activities of daily living and the administration of oral medication, were generated via observation, interviews and focus group discussion with 144 family members (children aged up to 15 and their parent/s) and 65 nurses and Health Care Assistants. All data were subjected to thematic analysis.

**Results** Although parents generally considered it their 'duty' to provide basic care for their children while in hospital, they did not necessarily know what they were 'allowed' to do or how they might achieve this. This role confusion was particularly significant during acute, short stay hospitalisations. Nurses recognised the vital role that parents' play in care provision and considered it their responsibility to control and direct negotiations with family members. Both parents and nurses valued informal aspects of care negotiation and neither considered formal contracts to be the way forward.

**Conclusions** There remains clear evidence of a gap between the principles and practice of FCC, particularly during one-off and short stay hospitalisations, which account for a significant proportion of all admissions. This paper will conclude by suggesting approaches that may enable parents' participation in their child's care that could also be, on the basis of our findings, acceptable to nurses.

### G237 FAMILY-CENTRED CUBICLES? ISSUES ASSOCIATED WITH DELIVERING AND RECEIVING CARE IN CUBICLES

<sup>1</sup>A Northcott, <sup>1</sup>P Curtis, <sup>2</sup>J Reid. <sup>1</sup>School of Nursing and Midwifery, University of Sheffield, Sheffield, UK; <sup>2</sup>Sheffield Children's NHS Foundation Trust, Sheffield, UK

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**Aims** Spatial aspects of hospitals have received scant attention in research on Family Centred Care (FCC). Presently, cubicles are used predominantly to isolate patients that present an infection risk or that require a heightened level of observation. Though shared bays remain a common feature on children's wards, new builds tend to increase the number of cubicles at the expense of bays. This paper explores the experiences and expectations of nurses and family members as they provided and received care in hospital cubicles.

**Methods** A 10 month, focused ethnographic study was carried out in 2 medical and 2 surgical wards in a Children's Hospital in the North of England. Data, focusing upon activities of daily living and the administration of oral medication, were generated