Children's Support Worker Competency Framework

Name: ……..

Clinical Area: ……

Manager: ……

Clinical Educator: ……..

Preceptor: ……

Date Commenced: ……

Date Completed: ……

Welcome

This booklet contains your record of training, progress reports and clinical competencies for you to complete.

You will be allocated to work alongside trained members of the nursing team in order to achieve your competencies and you will be supported throughout; with your named supervisors and Clinical Educators on hand to guide you.

You will have plenty of supported opportunities in which to observe and begin learning new skills.

Please be reassured that you will be supported until such time you feel confident, this will be discussed at each of your meetings.

Should you need any help or support at any time please contact the Clinical Education team for advice.

Thank you

The Clinical Education Team

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We are here to support you in your new role in our Trust.

Trust Signature Behaviours

Making the Trust a better place for our staff, our patients and our local community is the ultimate goal of 4ward, so we want everyone to focus on how we behave, what we deliver and create a culture we can all be proud of.

Record of Sign-off Signatures

Name of Assessor	Designation	Signature	Date

Agreement

Staff Name:	
Supervisor:	
Line Manager:	

Period of Supervision

Start Date:

……

We agree to use this time to review progress and discuss individual learning needs and objectives.

Initial Meeting: ……

3 Month Review:……

6 Month Review: ……

9 Month Review: ……

Final review & sign off:……

I agree to support the Childcare Support Worker's programme, agreed meetings and to review progress on these dates. We agree to review the documentation, learning outcomes and objectives set by the supervisor and support worker as required.

Signature: ……

Supervisors Signature: ……

Date: ……

Understanding your role

The kinds of duties that will be required of you are:

Providing care and support, working in a person-centred way, communicating well, building relationships and promoting equality and diversity.

Working as part of a team, being a supportive team member and developing your skills to improve your work

Contributing to activities in a safe way, keeping and filing clear records, keeping to regulations, following the agreed way of working

Respecting confidentiality by not discussing any personal information on individuals or staff with unauthorised people, and storing records securely.

Regulations are rules that come from legislation or laws. The legislation establishes the general 'laws of the land'. Regulations provide the specific ways in which those laws are interpreted and applied.

The Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England.

This has the moral and ethical standards expected of all health and social care workers. The Code can be found at either: www.skillsforcare.org.uk/code-of-conduct or www.skillsforhealth.org.uk/code-of-conduct

Confidentiality

The Data Protection Act 1998 protects people's rights to confidentiality. It restricts how personal and sensitive information can be used, stored and passed on. Personal details must not be passed on unless the person gives their permission. These laws give you rights as an employee but also require you to treat individuals' information responsibly. You should only pass information on in line with your employer's procedures and for the purpose of providing the best care. You can find more information about the Data Protection Act 1998 here: www.gov.uk/data-protection/the-data-protection-act

Reporting errors

We are all human and mistakes sometimes happen. When mistakes are made it's important to be honest and identify where errors have happened. This will allow: action to be taken that may reduce the impact of the mistake lessons to be learnt through thinking about and agreeing what went wrong.

Please see Trust **Incident Reporting Policy WHAT-CG-008 Version 10** for up to date guidance on incident reporting.

Whistleblowing

Your employer should provide or explain their whistleblowing policy. You have a responsibility to report things that you feel are not right, are illegal, or if anyone at work is neglecting their duties. This is known as 'whistleblowing'. In most cases you should discuss your concerns with your manager. However, if you felt

that it was not appropriate to speak to your manager for some reason, you should follow your employer's whistleblowing procedure and ways of working.

Working in partnership

Your role will involve you working with many people who have a variety of roles. This is known as 'partnership working'. Developing good relationships will help to improve the quality of care provided.

The main working relationships in health and social care can be categorised in four ways: individuals and their friends and family your colleagues and managers people from other workplaces, including advocates, volunteers and community groups.

Advocate: *Someone who provides support by speaking for an individual on their behalf.*

Not all of the individuals you support will be confident or able to speak out. If their care is inadequate or they are treated in ways that do not uphold their rights you must support them to make a complaint, or raise concerns yourself.

Good communication between everyone is essential. Health and social care workers must trust, value and respect one another, having belief in everyone's ability to work together to achieve shared goals.

For communication to be good and effective it must be open, accurate and understandable. Ways of communicating and language must be right for the individual so you can be sure that they understand what is being said. Workers should avoid using jargon which can be misunderstood.

Communication : *Effective communication is central to a successful workplace for both individuals and staff alike.*

When working with people who have communication needs, it may be necessary to consider translators, pictures or communication boards to support them to communicate well.

Duty of care

Duty of care is a legal requirement; you cannot choose whether to accept it. It applies as soon as someone has care or treatment. Breaking this duty, for example through negligence, could result in legal action.

Your duty of care is also to other workers, for example, in a hospital, to doctors, nurses and healthcare support workers but also to caterers, cleaners and maintenance workers. Your duty of care is to each individual and to the other workers you come into contact with in the community.

The duty of care is part of the code of conduct for healthcare support workers and adult social care workers in England and will most likely also be in your job description. It is important that you have the knowledge and skills to act on your duty of care in your role but that you don't work beyond it.

Patient Feedback and complaints

You have a duty to make sure that each individual knows that they have a right to complain or comment about their care or support. It is important that this is able to happen quickly and in a positive way. They should be taken seriously and explored so that any learning can be used to keep doing the right things or

to make improvements. Positive comments can be encouraging and used to show how good ways of working are making a positive difference. Ask your employer to tell you about what to do when someone wants to complain or comment.

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 are the legislation for complaints in health and social care. The Department of Health also published the NHS Constitution in 2011, which tells you about guiding principles and patients' rights. There should be a recorded process to follow which may differ depending on the type of workplace and have a time limit in which the complaint has to be made after the situation happened. If someone wants to make a comment or complaint you should deal with it in line with your organisations agreed ways of working. Depending where you work, that could include:

- arranging to talk in private
- making sure the individual knows that you may need to pass on information if there is a risk to the safety of themselves or others
- listening calmly and actively, assuring them that you are taking them seriously
- not judging or becoming emotional
- offering your support but not trying to answer the issue before the agreed way of working has taken place
- explaining what will happen next, who the complaint will be passed to and when the person will get some feedback.
- Mistakes happen through things like lack of knowledge, poor communication or not sharing information, stress, negligence or being distracted. Mistakes are seen as being one of the following:

Incidents, errors and near misses

- **Adverse events:** action or lack of action that leads to unexpected, unintended and preventable harm.
- **Incidents:** specific negative events. In health and social care serious incidents are described as events which need investigation as they caused severe harm or damage to either the person receiving care or the organisation.
- **Errors:** not doing something as it should have been done, for example through bad planning or being forgetful.
- **Near misses:** situations where an action could have harmed the individual but, either by chance or purpose, was prevented.

Legislation

For health and social care work a variety of legislation sets standards on how to handle issues to improve services and positive outcomes.

The Health and Safety at Work etc. Act 1974

This is the main piece of legislation covering occupational health and safety in the UK. It places a duty on employers and employees for the health, safety and welfare of persons in the workplace. www.hse.gov.uk/legislation/hswa.htm

The Control of Substances Hazardous to Health Regulations 2002 (COSHH)

This requires employers to assess the risks of potentially harmful substances and take precautions to minimise these. They include, for example, cleaning materials and medication. www.hse.gov.uk/coshh/

The Provisions and Use of Work Equipment Regulations 1998 (PUWER)

Anyone responsible for work equipment should ensure that it is suitable for the job, well maintained, inspected regularly and only operated by well-informed and trained staff. A breach of any of these regulations is a crime in the UK and therefore needs to be reported immediately. If any person suffers harm as a result, the offender may be taken to court. www.hse.gov.uk/work-equipment-machinery/puwer.htm

The Management of Health and Safety Regulations 1999

Workplaces should have a procedure in place for recording, reporting and evaluating all serious incidents. They should take measures to avoid them happening again.
www.legislation.gov.uk/uksi/1999/3242/contents/made

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

This places duties on responsible persons working on the premises to report specific workplace accidents, occupational diseases and specific dangerous occurrences or near misses to their local Health and Safety Executive (HSE). www.hse.gov.uk/riddor/

Managing conflict and difficult situations

There are many things that can cause conflict with and between people. Conflict or 'behaviour that is challenging' often happens as a result of distress or because needs are not being met. It could be caused by a number of factors including: biological, for example because an individual is in pain or suffering the side effects of medication or substance misuse social, for example because of being bored, wanting social contact, having a need to be in control, not being able to communicate or understand what is being said environmental, for example because of loud noise or bad lighting or barriers to mobility psychological, for example because of feeling left out or lonely.

An open discussion with any individual, where they are treated with respect and dignity, can often find a solution. If possible and safe, when working with a person whose behaviour is challenging:

- take them to a quiet place
- ask questions and listen carefully to what they say
- take their feelings of being upset or angry seriously
- try to find a way forward that they understand and can agree to.

It is important that you get to know the individuals you are working with as far as possible, so you can recognise what triggers their distress. It is also important that you don't get emotionally involved but keep a clear head and look out for body language and reactions. If you feel that a one-to-one situation between yourself and an individual has the potential to become confrontational you should try to leave the scene to give them time to calm down.

When you recognise frustration and aggression in a person's behaviour you will learn, as you develop in your role, how to use your communication skills and other ways of working to manage a situation before it becomes violent or aggressive. Your manager will provide guidance, explain ways of working and support you to develop your knowledge and skills as you progress in your work.

Values are beliefs and ideas about how people should behave which have been formed by our childhoods, families, backgrounds, cultures, religions, educations and relationships. Whilst we each have our own values there are values which are important for working in health and social care.

Values in Health & Social Care

Values *are central to work in health and social care. They are principles that guide workers to understand right from wrong and are about what is important when caring and supporting individuals.*

Six values are now recognised as applying to health and social care workers. These are known as 'The 6 Cs':

- Care: having someone's best interests at heart and doing what you can to maintain or improve their wellbeing.
- Compassion: being able to feel for someone, to understand them and their situation.
- Competence: to understand what someone needs and have the knowledge and skills to provide it.
- Communication: to listen carefully but also be able to speak and act in a way that the person can understand.
- Courage: not to have fear to try out new things or to say if you are concerned about anything.
- Commitment: dedication to providing care and support but also understanding the responsibility you have as a worker.

Another way of looking at the 6 Cs is that each individual must be placed at the centre of their care and support. It must fit the individual, rather than the individual being made to fit existing routines or ways of doing things. This is known as person-centred working. Person-centred values tell you how to work in a person-centred way.

The importance of effective communication

Good communication develops your knowledge and understanding about individuals and the part played by other workers so that the best care and support possible can be provided. It helps build working relationships where each person's views are valued and taken into account.

Communication is an essential part of a caring relationship and helps to encourage trusting relationships with other workers and families as well as the individuals you care for.

Types of communication

Talking is often seen as the most common method or type of communication but most communication is silent. Gestures, tone of voice, grins, grimaces, shrugs, nods, moving away or closer, crossing arms and legs all tell us far more than words. Learning to take account of these reactions is all part of developing your communication skills to achieve the best outcomes for individuals. Communication can be harder when we can't see these signs such as when we use the phone, texts or email.

Different people have different ways of communicating that work best for them. Some of the different types of communication are:

- **Verbal communication** - Differences in how you speak, including the tone, pitch, speed and volume of your voice could change how your messages are taken in. Try to avoid using jargon or abbreviations and complicated words and terminology. Make sure you always speak in a respectful way, adjusting your speech to suit the individual.
- **Sign language** - This is a recognised language throughout the world. British Sign Language (BSL) is used by individuals in this country and there are variations of sign language in different regions.
- **Makaton** - This is a form of language that uses a large collection of signs and symbols. It is often used with those who have learning and physical disabilities, or hearing impairment.
- **Braille** - Is a code of raised dots that are 'read' using touch. For people who are visually impaired or who are blind, the system supports reading and writing.
- **Body language** – This is a type of nonverbal communication. There are many different aspects of body language, including gestures, facial expressions, eye contact, body positioning and body movements. Each of these will communicate information about an individual or a worker often without them realising it.
- **Gestures** – These are hand or arm movements that emphasise what is being said or used as an alternative to speaking.
- **Eye contact** - Maintaining good eye contact is an important way for a worker to show that they are engaged and listening.
- **Position** - The way that we stand, sit or hold our arms when we are talking will provide others with clues about our feelings, attitude and emotions.
- **Written communication** - This method is used to send messages, keep records, or provide evidence.

Barriers to effective communication

A barrier is anything that will get in the way of communication. There are a wide range of barriers including:

- Attitude – When a worker is abrupt due to time limits, not having enough resources or their mood, the person they are speaking to may feel intimidated or frustrated and not want to communicate.
- Limited use of technology – When the technological aids known to be the best way for someone to communicate are not available.

- Body positioning – Sitting too close could be intimidating and would make an individual feel uncomfortable. Sitting too far away could show lack of interest or concern.
- Emotions – When someone is depressed, angry, embarrassed or upset their emotions may affect their ability to think and communicate in a sensible way.
- Physical – When someone has physical conditions that create communication difficulties, for example, being breathless, not having any teeth or being in pain.
- Not enough time – Not giving individuals time to say what they want may make them feel rushed and reluctant to express their true wishes.
- Poor or negative body language – Crossed arms or legs, poor facial expressions, poor body positioning, constant fidgeting or looking at a watch or mobile phone can all make someone less likely to communicate.
- Lack of privacy – Think carefully about where and when private and confidential conversations should take place.
- Stereotyping – Generalisations about a group of people that are wrong and misleading. An example would be that 'all older people are hard of hearing'.

Other barriers include sensory impairments, culture, language, noise, lighting or substance misuse.

Communication in summary

Communication may take place face-to-face, by telephone or text, by email, internet or social networks, by written reports or letters. It requires you to listen or read (and understand) as well as to speak or write. Whether you are communicating face-to-face, on the telephone or in written form, always be respectful, try to match your method of communication to the individual's needs and be aware of confidentiality.

Record of Training

Completion of training is linked to your annual Professional Development Review (PDR). Please provide evidence below of attendance on study days and completion of e-learning. E-Learning can be accessed on you Electronic Staff Record (ESR) together with details of employment, payroll information, annual leave entitlement and your training record.

STATUTORY AND MANDATORY TRAINING REQUIREMENTS	Date of Completion
IT clinical system training e.g. Oasis, Bluespier, ICE requesting, ADT Whiteboard etc. No access to clinical systems will be given until IT training is complete.	
Trust Induction	
Fire training (annually)	
Infection Control (annually)	
Manual Handling (2 yearly)	
Health & Safety (3 yearly)	
Information Governance (yearly)	
Equality & Diversity (3 yearly)	
Safeguarding Children (must complete most appropriate level for the role) (3 yearly)	
Safeguarding Adults (must complete most appropriate level for role) (3 yearly)	
Resuscitation (yearly)	
Conflict Resolution (3 yearly)	
Blood Transfusion (2 yearly)	
Medical Devices	
Violence & Aggression	
Medicines Management/ Fridge Temperature Monitoring	
WRAP/Prevent Radicalisation (3 yearly)	
NEWS 2 - Training	
Infant Feeding Training (yearly)	

N.B. This is only to be used as a guide. Please use ESR for your up to date training records.

Medical Devices Training Assessment Tool

Medical Device	Level of risk H/M/L	Applicable to my practice? Y/N	I am familiar with all models used in my department and do not require training. Y/N	I require training in the use of this medical device. Y/N	Date of training
Glucose analysers	H				
Infusion Devices 1.Braun Infusomat 2.Perfusor Space(Syringe Driver) 3.PCA	H				
Defibrillators	H				
Resuscitation Equipment	H				
Respiration Apnoea Alarms	H				
Incubators	H				
Humidifiers	M				
Monitoring equipment 1.Pulsoximeters 2.Vital Signs Monitor 3.Thermometers – Electronic	M				
Nutrition Feed pumps	M				
Peak Flow Meters	M				
Pressure relieving equipment	M				
Scales (Patient): Baby Standing	L				
Oxygen/air flow meters	L				
Suction	L				
Breast Pumps	L				
Bed Pan Washer	L				
Any other equipment used:					

SWOB/T Analysis

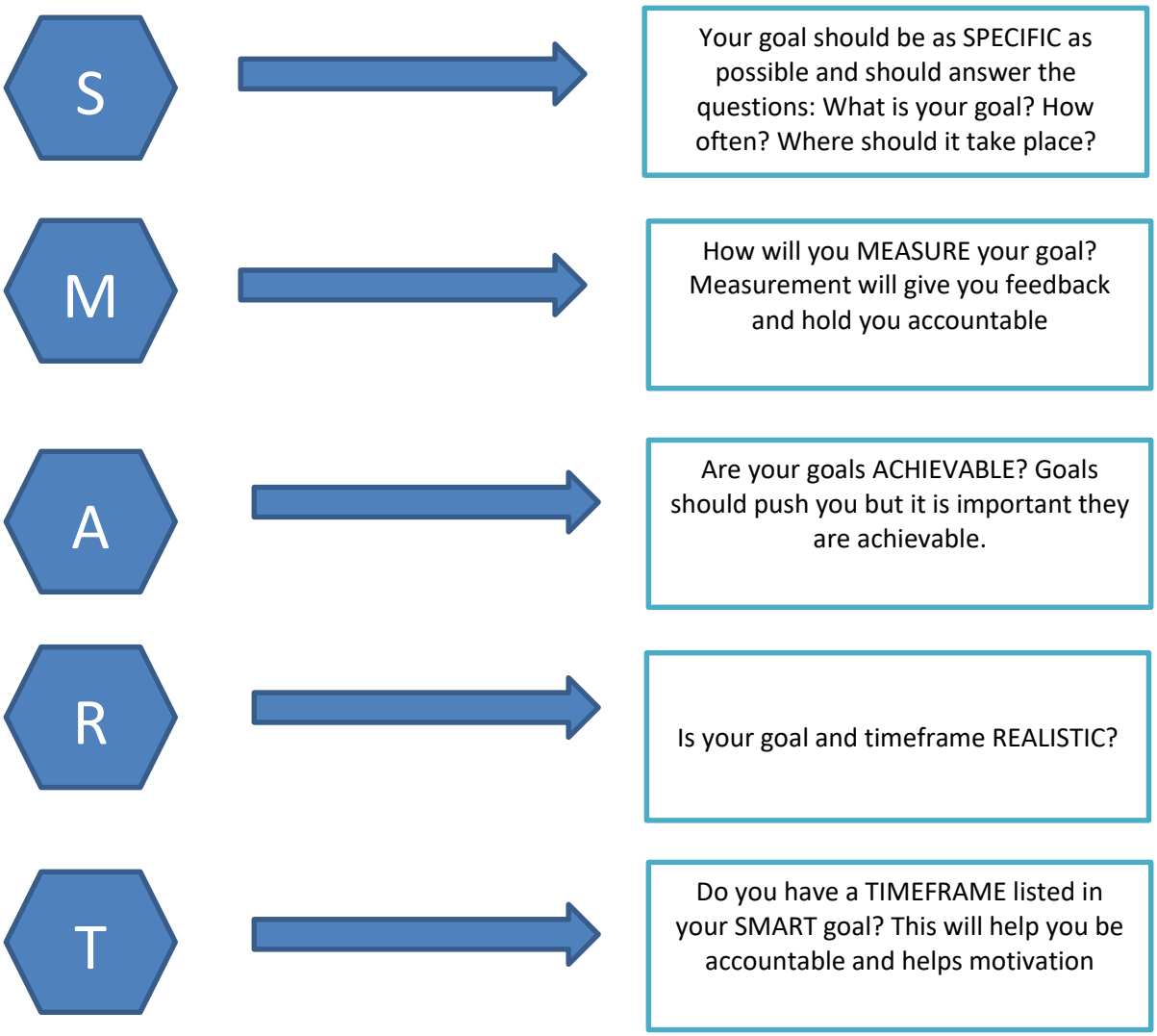
Please complete this self-assessment before your initial meeting with your preceptor to help identify any learning needs.

What are your strengths?	What are your weaknesses?
What opportunities are there for you?	**What barriers or threats are there?**

Setting Objectives

Your objectives are the things that you would like to achieve. Always agree your objectives with your preceptor. Objectives are easiest to agree if you keep them 'SMART'.

Once you have clear SMART objectives, it is time to break them down into manageable action points and record this information.



Initial Meeting

This must be completed within the first week of the preceptorship programme.

Ensure all areas are discussed during your first meeting:

- Fire & evacuation procedure ☐
- Action to be taken in the event of an emergency ☐
- Shift patterns & how to request off duty ☐
- Manual Handling Policy ☐
- Infection Prevention & Control policy and procedures ☐
- Health & Safety at work regulations ☐
- Policies, procedures & guidelines and how to access them ☐
- Protection of vulnerable individuals ☐
- Policy for telephone enquiries on the unit ☐
- Sickness and attendance policy ☐
- How to report sickness absence ☐
- Uniform Policy/Dress code (including PPE) ☐
- How to use bleep system ☐
- Information on car parking passes ☐
- Relevant local patient documents – care plans, charts etc ☐
- Available learning opportunities ☐
- Any additional support required ☐

Date of meeting: ……

Review job description, identify gaps in your knowledge and skills and how to meet these.

Objectives:

(for example: obtains Trust email address, computer login etc.)

Courses/Learning Opportunities:

(For example: Bluespier/ICE/Oasis, Blood Glucose Monitoring etc.)

Preceptor Feedback:

Preceptee Feedback:

Preceptee's signature: ……

Preceptor's signature: ……

HCA Competencies

Basic Vital Signs
PEWS Calculations
Fluid Balance
Pain Management
Nasogastric Feeding
Nutricia Flocare Pump Training
Urine & Stool Sample Collection
Urinalysis
Mental Health Assessment
Safeguarding
Communication
Consent
Play / Distraction
Chaperone
Patient Experience
Documentation

Person Self Assessment

- This assessment should be completed upon commencement in post. You should then repeat the exercise after your first 3 months.
- Your mentor will assess your performance on the same competencies at the end of the programme.
- Please rate yourself on a scale of 1-5 with 1 being the lowest and 5 the highest.

Competence	Example	1	2	3	4	5
Considerate	• Offering to help colleagues • Being courteous to staff who come to help					
Conscientious	• Making sure jobs are done properly and finished off • Noticing things and putting things right					
Positive	• Smiling at work and at each other • Not moaning or complaining in inappropriate ways or places e.g. in front of patients or visitors • Being open to new ideas and making your area a great place to work.					
Team orientated	• Being flexible with work shifts • Helping each other and being courteous • Offering to get involved without waiting to be asked					
Friendly	• Smiling at everyone and anyone • Offering to help people and being positive • Looking out for anyone that may need help without waiting to be asked e.g. looking up from your desk					
Honest	• Telling the truth at all times • Owning up to mistakes • Being trustworthy and reliable • Not being two-faced					
Reliable	• Turn up for work regularly and on time • Always do what is asked or what is expected • Be dependable					
Customer Focused	• Put service users (including colleagues)needs above your own where necessary • Treat people as they wish to be treated not how you think they wish to be treated					
Patient Focused	• Put the needs of the patients first above your own where necessary • Ensure all tasks/projects and targets ultimately meet the needs of patients e.g. if doing an office project					
Open to Change	• Being positive and flexible • Attending team/area meetings, making sure you are aware of changes • Ask questions of the changes if necessary • Keeping an open mind and heart					
Have Initiative	• Take the lead on projects or issues					

	• Recommend ideas to managers • Being the first to do or think of something or doing it without waiting to be asked					
Respectful	• Being aware of other peoples roles and responsibilities • Being mindful of other people's needs, values and opinions					

Learning objectives to be achieved on the ward within the orientation period

1. Participate in, and discuss the basic care needs of the patient
2. Observe and participate in the preparation of a bed space to take a patient for admission
3. Observe and participate in preparation of a theatre pack/bed
4. Discuss the needs for the preparation of a prompt serving of meals/drinks
5. Observe and discuss the procedure for reporting broken equipment
6. Observe and discuss the procedure for recording patients belongings/valuables
7. Understand and demonstrate the principles of barrier nursing
8. Understands the need for and demonstrates effective hand hygiene technique and can describe the 5 moments of hand hygiene
9. Understands the need for and demonstrates competency of the daily required bed checks
10. Discuss possible complications / emergencies that may occur and what actions you should take
11. Discuss your role in reporting concerns/changes in the patients condition to the qualified staff
12. Discuss and demonstrate a basic understanding of the different cleaning products we use on the ward and where they should be used.
13. Know where the Pod system is for sending specimens to the lab and how to use this
14. Can discuss the implications of poor care/service

HCA General Competencies

Competency	Date Achieved	Assessors Signature	HCA's Signature
Demonstrates recognition of the need for Health & Safety issues i.e: • Awareness of risks i.e. needle stick injuries • Location of relevant documentation on Trust intranet • Taking broken equipment out of service and the reporting process • Wet floor signs • Basic understanding of waste disposal consideration			
Can demonstrate competency in reporting broke equipment including completion of a decontamination form where appropriate			
Can discuss the principles of negligence of care			
Can discuss the need to maintain patient confidentiality			
Can discuss and demonstrate a basic understanding of the different cleaning products we use on the ward			
Can demonstrate the correct frequency and process for commode cleaning using correct wipes and documenting appropriately			
Ward Routine			
Can discuss and demonstrate awareness of their role within the ward routine			
Demonstrates competency of the role requirements within the ward routine, cleaning and bed making etc.			
Communicates well with all members of the ward staff and MDT as their role demands			
Can work with the team to deliver meals and drinks in a competent timely manner			
Communicates appropriately with patients and relatives to make them feel welcome etc.			

Competency	Date Achieved	Assessors Signature	HCA's Signature
Ensures that the patient has fluids and meals ordered if not nil by mouth			
Can provide family members information on visiting times, mealtimes, restaurant times, facilities available i.e. parents room, play room, young people's room, TV service, WiFi access			
Ensures the patient has the nurse call and bed table and drink etc within reach			
Ensures that patient has been orientated to the bay/ward			
Informs the qualified staff if the patient expresses any anxieties			
Hand Hygiene			
Is able to discuss and describe the importance of hand hygiene, and can state the 5 moments of hand hygiene			
Discuss when it is appropriate to wash hands with soap and water			
Discuss when it is and isn't appropriate ti use hand gel and the correct method of applying			
Observed undertaking the correct hand washing technique			
Bed Bathing			
Can discuss the need to obtain the patients consent before starting the bed bath or assisted wash			
Completely and confidently gathers all necessary equipment			
Ensures the environment is suitable to commence the bed bath i.e. curtains around the patient, windows are shut and that the water is at a comfortable temperature for the bed bath			
Can discuss and demonstrate the need to maintain the patients dignity during the procedure			
Confidently and thoroughly completed the bed bath			
Can discuss and demonstrate the process of bathing an infant, ensuring room and bath water is at the correct temperature			
Communicates effectively with the patient throughout the procedure			

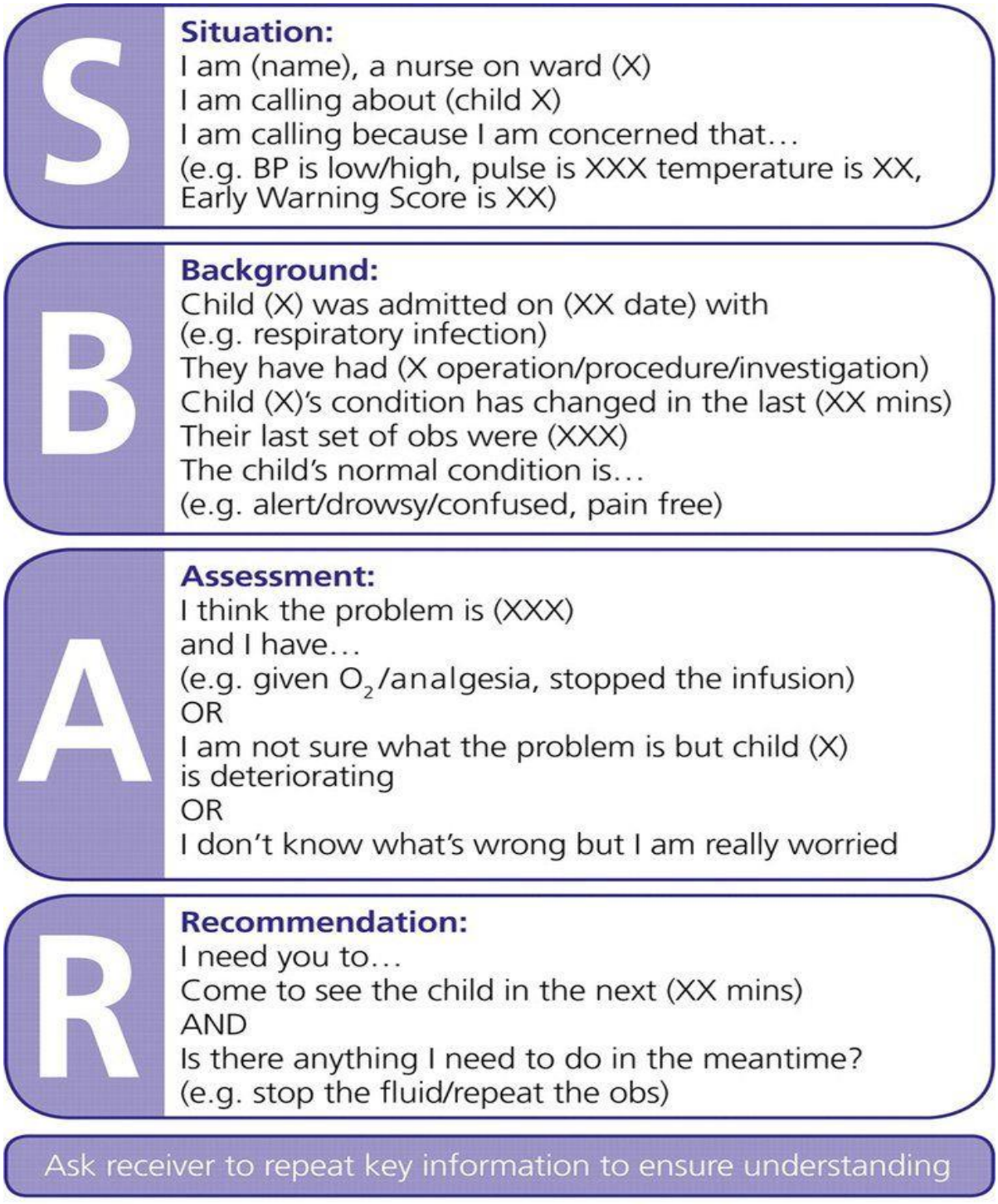
Competency	Date Achieved	Assessors Signature	HCA's Signature
Demonstrates effective consideration of infection prevention and control issues i.e. clean sheets/dirty sheets, hand hygiene			
Can discuss the need to report any skin changes both new and / or deterioration in the patients skin to a qualified nurse			
Knows the process to arrange for a pressure relieving mattress and how prepare this for use			
Barrier Nursing			
Is aware of where to find the Trust infection prevention and control documents			
Can discuss and gather the necessary required equipment to provide barrier nursing care for a patient			
Can discuss and demonstrate good principles of barrier nursing			
Can discuss and demonstrate the ability to use Personal Protective Equipment (PPE)			
Demonstrates good hand hygiene and can discuss principles to prevent cross infection effectively			
Can demonstrate the correct cleaning procedure for a barrier room during the admission and on discharge			
Can demonstrate correct use of barrier nursing warning signs i.e. protective isolation etc.			
Daily Checks			
Can discuss the required daily checks on the ward			
Demonstrates ability to perform the checks competently and confidently			
Demonstrates assembly of suction canisters competently – ensuring ready for use when completed.			
Knows where required equipment is stored to replenish stock			
Can discuss and demonstrate the process for setting up, closing, labelling and appropriately disposing of sharps bins			

Competency	Date Achieved	Assessors Signature	HCA's Signature
Can discuss and demonstrate the ability to complete the daily ward cleaning schedule			
Emergency Situation			
Can discuss the required action to take if a patient's condition suddenly deteriorates or they collapse. • Call for help • Emergency call bell			
Can explain the process to phone for the emergency team – 2222			
Is aware of their role in an emergency situation – ensure resus team are sent to correct location, running for equipment, stock, support for family			
Can discuss the implication that an emergency situation can have on other patients and families and offers support to these patients			
Understands the need to replenish any used stock as soon as possible after the event and where to locate the stock from			
Understands that there may be a need to talk with colleagues after the event to reflect on what they have learnt and what would they do differently next time			
Quality Patients/Family Experience			
Can discuss the need for improved patient experience whilst they are in an acute hospital setting and how the HCA's role can play an important role in this			
Communicates effectively to the nurse in charge of the ward any expressions of concerns, anxiety or complaints from the patient, relatives or carers			
Communicates politely and effectively with the patients from admission to discharge and can discuss barriers which can lead to poor communication i.e. body language, use of jargon			
Demonstrates ability to understand and promote the principles of Equality and Diversity whilst working with patients			

How to Escalate Concerns Using SBAR

Either escalate concerns to buddy nurse, nurse in charge or bleep medical team

How to Bleep: dial 60 then wait for automated response then dial bleep number followed by the extension number of the phone you are calling from.



Paediatric Early Warning Score (PEWS)

The paediatric early warning score is a tool that has been introduced to help identify any changes in a child or Young Persons condition early so prompt interventions can be made to help prevent acute deterioration in a patient's condition.
Observations performed will help to show signs that a child's condition is deteriorating so regular observations and early detection is key.
It is therefore important for professionals to recognise abnormal measurements and a deteriorating pattern and be able to act on them appropriately.

Early warning scores work by indicating the normal parameters for a patient and should any of the observations fall outside of these parameters it triggers a score which when totalled provides you with an overall warning score.

Paediatrics covers a wide age range 0 – 17 years of age, and the parameters vary dependent on age therefore it is important to have PEWS charts relevant to a patients age in order for the PEWS score to be an accurate representation of the child's condition.

Charts are arranged as follows:

- 0 – 11 months
- 1 – 4 years
- 5 – 12 years
- 13 – 18 years

(See Appendix 1)

At present PEWS scores total a maximum of 6, any child with a PEWS score of 3 or above needs to be escalated to the nurse in charge and the medical team and this needs to be documented clearly on the reverse of the PEWS chart or on a separate PEWS continuation sheet along with any interventions that have been made i.e antipyretics given, oxygen given etc.

It is good practice to ask the child and family how they are feeling, if they have any concerns or worries when carrying out observations. If parents express concerns please remember to include this in your PEWS calculation. Parents know their child best therefore if they are concerned you should be concerned.

It is important to always ensure you are using the right PEWS chart for the age of your patient otherwise your PEWS total will be incorrect and a deteriorating patient may be missed.

When a child / young person has a temperature their heart rate and respiratory rate can be elevated, which in turn elevates their PEWS score and may trigger sepsis. It is important the patient is then reassessed after one hour to see if there are any changes.
Please note that it is not acceptable to only record temperatures on a PEWS chart. If a child has previously spiked a temperature and you are checking to see if the temperature has resolved you should complete a

full set of observations to ensure the heart rate and respiratory rate has improved and the blood pressure remains stable.

Ensure any documentation is dated and timed and clearly legible and you must always initial any entry, which also needs to be countersigned by a trained member of staff.

As part of a patients observations there are other areas that need to be monitored, these are pain score, nausea score, capillary refill time (CRT) and sepsis triggers.

SEPSIS

What is sepsis?

Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. Normally our immune system fights infection – but sometimes, for reasons we don't yet understand, it attacks our body's own organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics. (Sepsis Trust 2020)

A patient's observations can help to identify if a child / young person is at risk of sepsis or triggering sepsis. Early identification of suspected sepsis is important as it can greatly improve the outcome.

While carrying out observations it is important to be aware of why the child is admitted or why they have been referred.

How to recognise a child is at risk of sepsis:

If a child with a suspected or proven infection AND has at least 2 of the following:

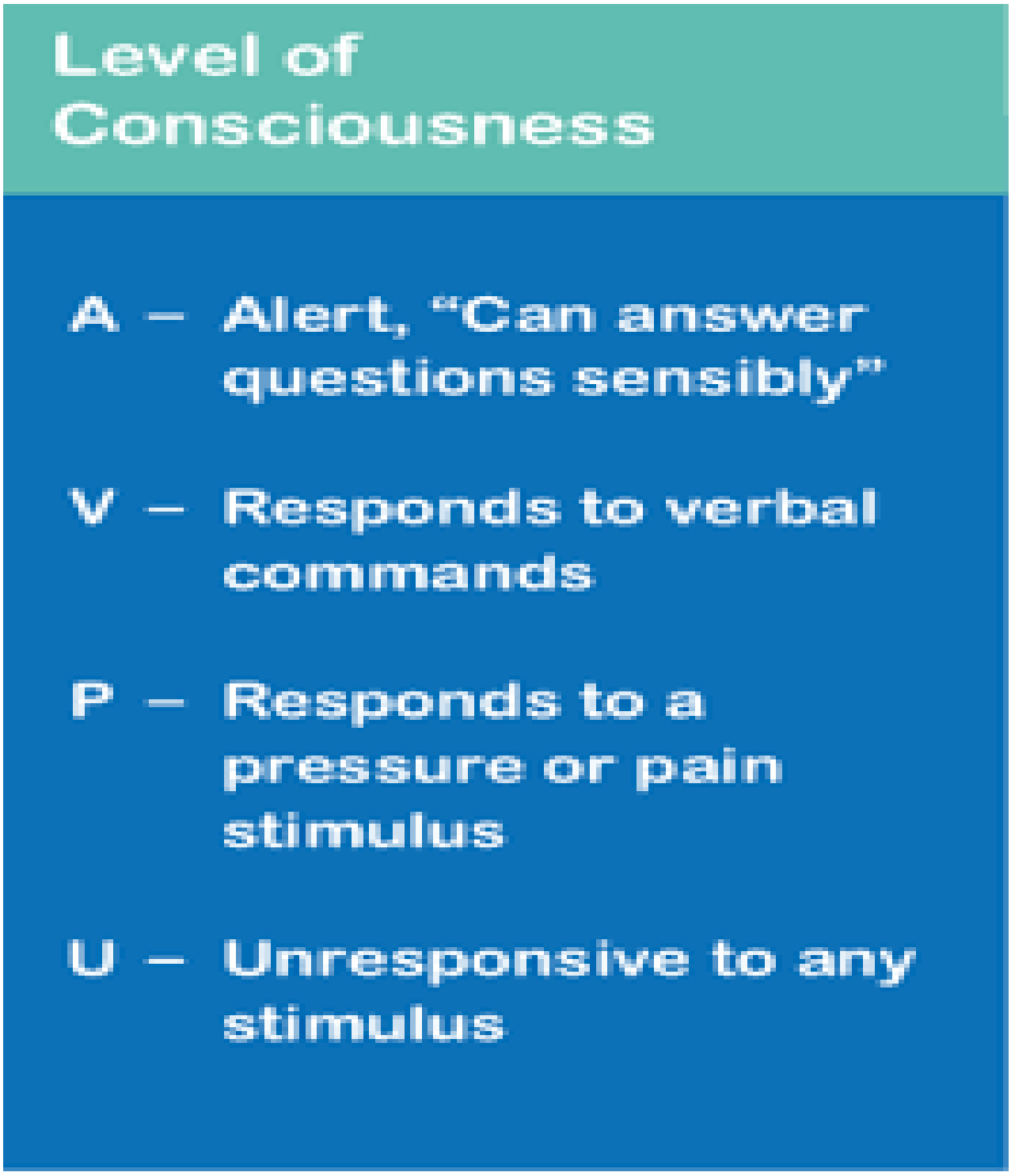
- Core temperature <36°C or > 38.5°C (38°C if immunocompromised)
- Inappropriate tachycardia:
  0-11 months - > 180 per minute
  1 – 4 years - > 140 per minute
  5 – 12 years - > 130 per minute
  13 – 18 years - > 110 per minute
- Altered mental state (including sleepiness, irritability, lethargy, floppiness)
- Reduced peripheral perfusion / prolonged capillary refill time.

Please note there is a lower threshold to trigger sepsis for: < 3 months, chronic disease, recent surgery or immunocompromised patients.

If you are in any doubt that a child may be septic even if observations are normal please inform a member of trained staff IMMEDIATELY so they can assess the patient and interventions can be carried out promptly.

If you do not feel confident in recognising sepsis then please inform a trained member of staff that you have not completed this part of the observations so they can then review the child.

AVPU



Only ALERT state is NORMAL!!

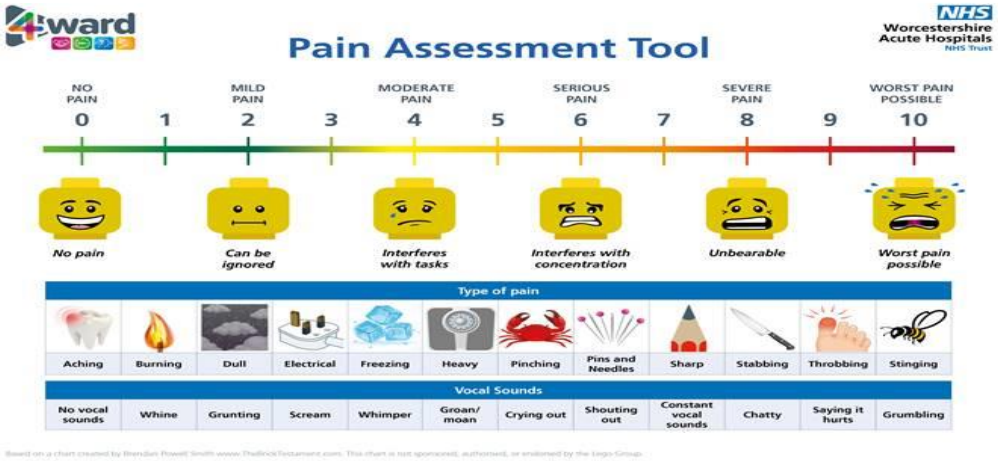
Pain Assessment

It is important to be able to accurately monitor a child / young person's pain score, in order for them to remain comfortable and their pain to be managed effectively. Pain scores are recorded on a scale of 0 – 10. Ideally we would like all patients to have a pain score of 0/10 and pain scores should be monitored regularly to ensure the patient remains comfortable.

A pain score of 3 or above should be escalated to a trained member of staff and documented on the reverse of the PEWS chart or a PEWS continuation sheet and analgesia should be given. The pain score alongside a full set of observations should be repeated after one hour to see if analgesia has been effective. This should continue to be repeated every hour until the pain score is less than 3/10.

To assist with assessing a child or young person's pain score we have pain assessment tools (please see below).

Lego Pain Assessment Tool



FLACC Pain Assessment Tool

CATEGORY	SCORING		
	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn	Frequently to constant quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
CRY	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

It is very important to maintain communication with the child / young person and their family with regards to their pain management and their pain threshold. Pain relieving actions / distractions can be discussed to see if these may help benefit the child / young person.

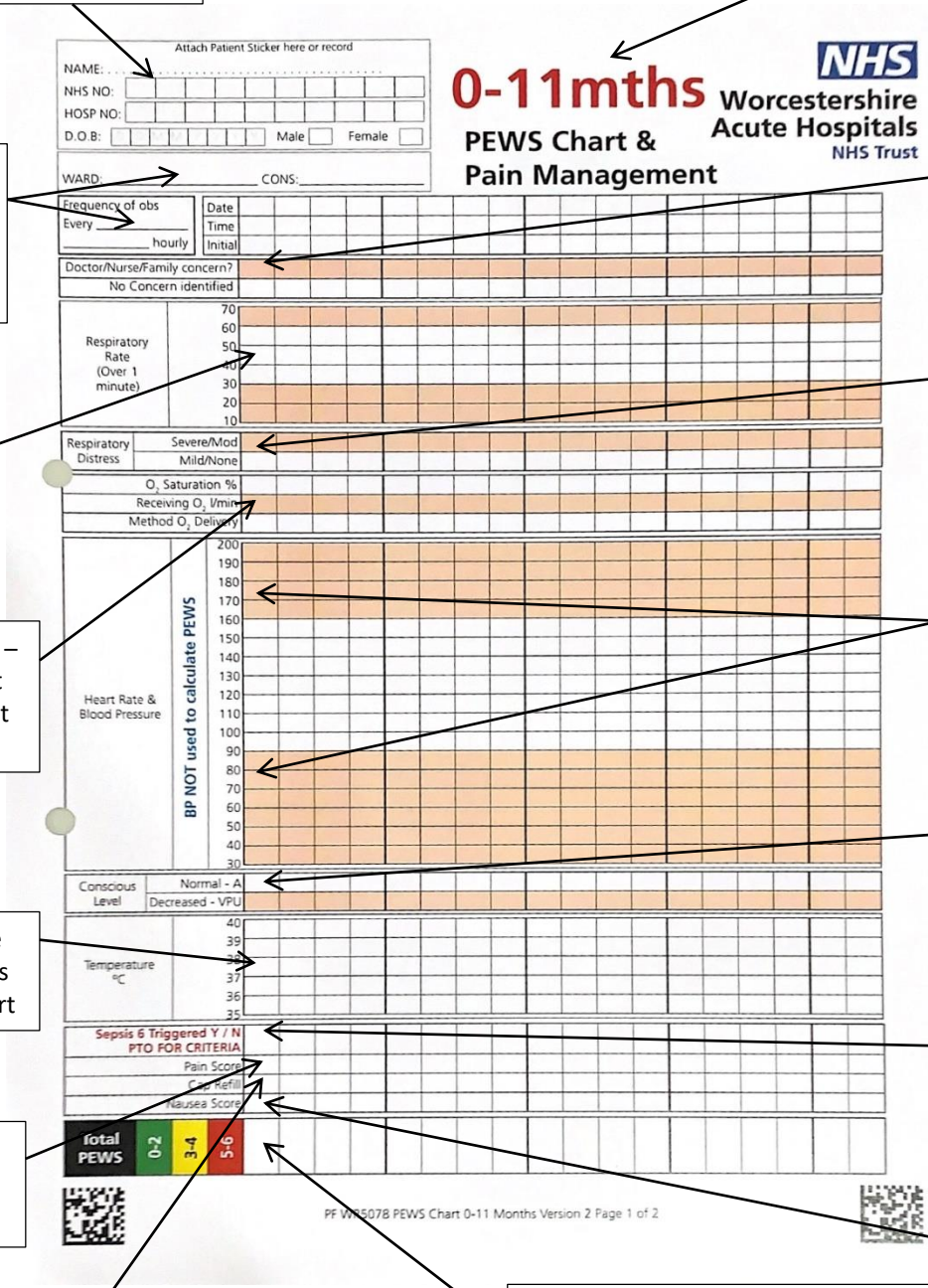
The use of play can help with distraction, liaise with the play specialists to see if they can offer any support.

It is important to note that even though a patient is asleep does not mean they are not in pain. Utilise the family, pain assessment tools and their observations to help you make an accurate pain assessment.

PEWS Chart

Affix patient sticker here – please do not use sticker with patient address on

Ensure you have the correct chart for the age of patient



Please write ward name, consultant & frequency of observations i.e 1-4 hours

Document if there are Doctor (D), Nurse (N), or Family (F) concerns or No concerns

Respiratory rate – any result in the orange section scores a 1.

Effort of breathing – see reverse of chart for degree of effort

Oxygen requirement – see reverse of chart on how to document oxygen delivery

Heart rate – any result in orange section scores a 1. Please note BP does not score on PEWS

Assessment of conscious level - AVPU

Temperature – please note temperature does not score on PEWS chart

Sepsis trigger – please see reverse of chart

Pain score – see reverse of chart for pain assessment

Nausea score – between 0-3 see reverse of chart

Capillary Refill Time – anything more than 2 seconds is abnormal

PEWS total – Scores between 0 – 6. Any result in an orange section is a score of 1. Any PEWS 3 or above needs to be escalated. See reverse of chart.

PEWS Chart Continued

PEWS escalation guide – provides directions on what to do dependent on PEWS score. However, if PEWS is 0 but you are worried still escalate to Nurse in charge

FLACC scoring – a method of calculating pain score between 0-10. Face, Legs, Activity, Cry and Consolability should be assessed.

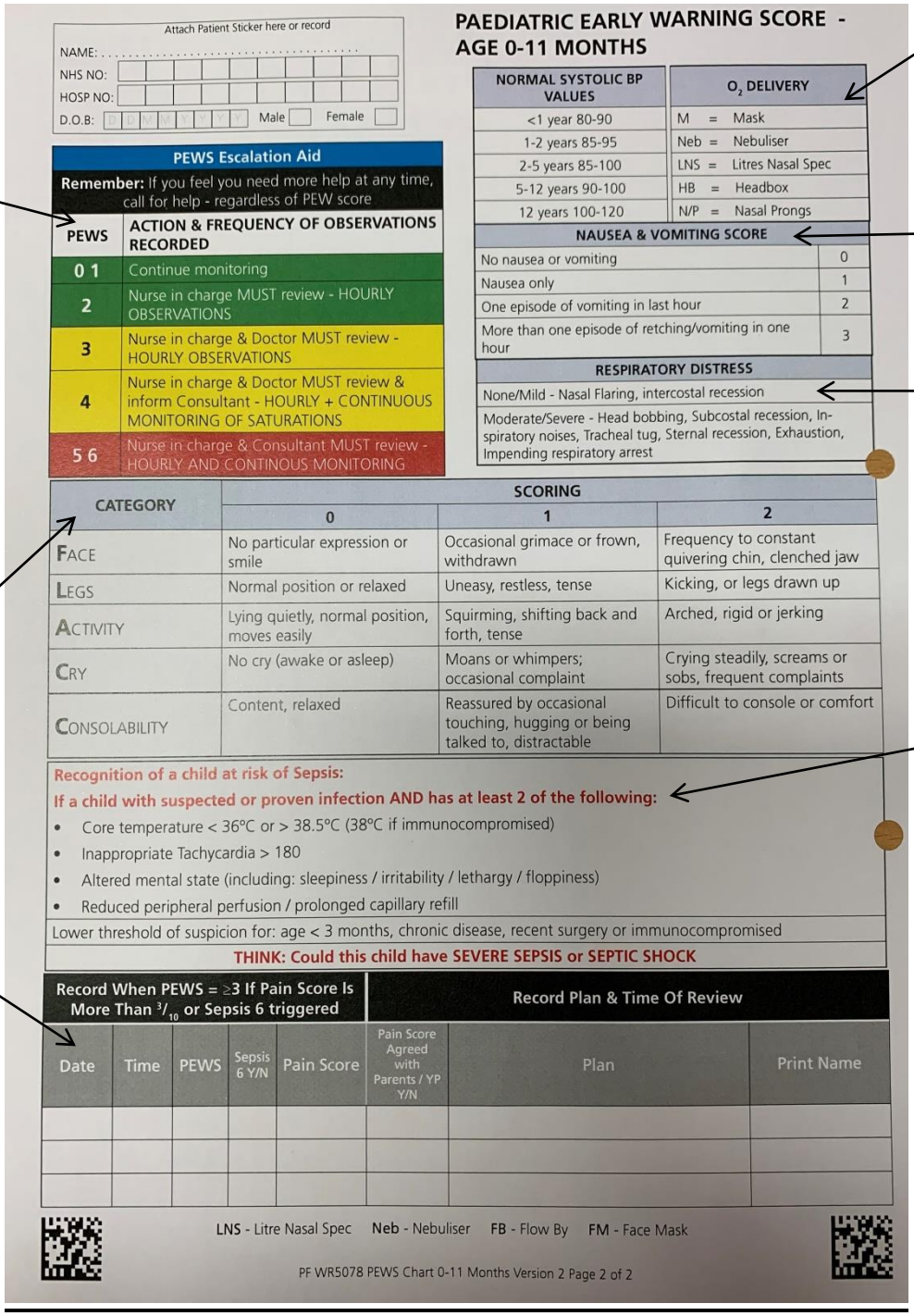
Escalation – if PEWS is 3 or above or a pain score of 3 or above this should be escalated here and a record of any interventions should be charted.

How to document method of oxygen delivery

How to calculate nausea score between 0-3

A guide to measure degree of respiratory

Recognition of sepsis – provides a guide to help assess if child is triggering sepsis.



Attach Patient Sticker here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D M M Y Y Male Female

PAEDIATRIC EARLY WARNING SCORE - AGE 0-11 MONTHS

PEWS Escalation Aid

Remember: If you feel you need more help at any time, call for help - regardless of PEW score

PEWS	ACTION & FREQUENCY OF OBSERVATIONS RECORDED
0 1	Continue monitoring
2	Nurse in charge MUST review - HOURLY OBSERVATIONS
3	Nurse in charge & Doctor MUST review - HOURLY OBSERVATIONS
4	Nurse in charge & Doctor MUST review & inform Consultant - HOURLY + CONTINUOUS MONITORING OF SATURATIONS
5 6	Nurse in charge & Consultant MUST review - HOURLY AND CONTINOUS MONITORING

NORMAL SYSTOLIC BP VALUES	O_2 DELIVERY
<1 year 80-90	M = Mask
1-2 years 85-95	Neb = Nebuliser
2-5 years 85-100	LNS = Litres Nasal Spec
5-12 years 90-100	HB = Headbox
12 years 100-120	N/P = Nasal Prongs

NAUSEA & VOMITING SCORE	
No nausea or vomiting	0
Nausea only	1
One episode of vomiting in last hour	2
More than one episode of retching/vomiting in one hour	3

RESPIRATORY DISTRESS

None/Mild - Nasal Flaring, intercostal recession

Moderate/Severe - Head bobbing, Subcostal recession, Inspiratory noises, Tracheal tug, Sternal recession, Exhaustion, Impending respiratory arrest

CATEGORY	SCORING 0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn	Frequency to constant quivering chin, clenched jaw
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
CRY	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractable	Difficult to console or comfort

Recognition of a child at risk of Sepsis:

If a child with suspected or proven infection AND has at least 2 of the following:

- Core temperature < 36°C or > 38.5°C (38°C if immunocompromised)
- Inappropriate Tachycardia > 180
- Altered mental state (including: sleepiness / irritability / lethargy / floppiness)
- Reduced peripheral perfusion / prolonged capillary refill

Lower threshold of suspicion for: age < 3 months, chronic disease, recent surgery or immunocompromised

THINK: Could this child have SEVERE SEPSIS or Sseptic SHOCK

Record When PEWS = ≥3 If Pain Score Is More Than $^3/_{10}$ or Sepsis 6 triggered					Record Plan & Time Of Review		
Date	Time	PEWS	Sepsis 6 Y/N	Pain Score	Pain Score Agreed with Parents / YP Y/N	Plan	Print Name

LNS - Litre Nasal Spec Neb - Nebuliser FB - Flow By FM - Face Mask

PF WR5078 PEWS Chart 0-11 Months Version 2 Page 2 of 2

Paediatric Early Warning Score – HCA Competencies

Performance Criteria	Description of Evidence Required	Level of Achievement / Grade	Date	Signature of Assessor
Theoretical Knowledge				
Understand the need for clinical observation				
HCA understands concept of PEWS				
Understands the differing normal ranges for different age children / Young people: • 0-11m • 1-4y • 5-12y • 13-18y				
Understands consent to carry out observations either through implied or verbal methods.				
HCA is knowledgeable about calculating PEWS score when not all basic vital signs have been completed				
HCA can demonstrate knowledge and accuracy of PEWS calculations				
HCA is aware of different PEWS charts and when NEWS may be used.				
HCA is knowledgeable about their role, responsibility and accountability regarding basic vital signs recording and documentation of PEWS.				
HCA is aware of sepsis 6 criteria				
Performing Basic Vital Signs & AVPU				
HCA is able to identify correct patient requiring basic vital signs recording and PEWS calculation and is able to locate correct patients charts.				
Is aware of infectious status and applies standard PPE if required and ensures adequate hand hygiene at all points of patient contact.				
Is able to identify the correct patient requiring basic vital signs recording.				
Give the relevant explanation of the intended intervention in language appropriate to the child.				
Give appropriate support and reassurance to the child/YP which is sensitive to their needs and concerns.				

Consent to carry out observations is given or implied by child / parents.				
Professional gathers correct equipment: • BP Machine (appropriate size cuff) • Thermometer (Tempadot / Tympanic) • Pulse oximeter (appropriate sized probe) • Timer				
Correctly attaches equipment and ensures that the patient is still comfortable and co-operative				
HCA performs basic vital signs recording: • Temperature • Manual Pulse • Respiratory Rate • Respirator Effort • Blood Pressure (BP) • Oxygen Saturations (SpO2) • AVPU • Capillary Refill Time (CRT) • Pain Score • Sepsis Triggers? • PEWS calculation				
HCA is able to document basic vital signs on correct age appropriate PEWS chart.				
Identifies if there are any signs of sepsis, escalates concerns immediately				
HCA can correctly assess patients conscious level using AVPU.				
HCA can correctly assess patients capillary refill time				
HCA can identify level of respiratory distress				
Is able to reassure the patient throughout the measurement and answer questions / concerns from the patient or their carers clearly, accurately and within their own sphere of competence and responsibility				
Ensures that the patient is left reassured and comfortable following vital signs measurement				
Calculating, Documenting & Completing PEWS Charts				
HCA can demonstrate correct calculation of PEWS score				
HCA can document accurate pain score				

- and where appropriate agree this with patient or family.				
HCA is aware to document any trigger of the sepsis 6 criteria				
Escalation of abnormal PEWS / Pain Score / Sepsis 6				
HCA can identify abnormal PEWS score				
HCA can identify relevant action to be taken in the event of an abnormal PEWS (scores 3 or above) or trigger of sepsis 6 or if pain score over 3, who to escalate it to and documents this on the reverse of the PEWS chart or PEWS continuation sheet.				
HCA can escalate concerns/abnormal PEWS score using SBAR to relevant member of nursing / medical staff in a timely manner.				
HCA can where possible, initiate treatment to reverse/improve patients clinical condition and improve PEWS / Pain score i.e oxygen therapy, re-positioning, alerting trained member of staff the need for antipyretics/analgesia				
Ensures all entries are countersigned by a trained member of nursing staff promptly.				
Refer any questions / concerns from or about the patient outside of your responsibility or sphere of competence to an appropriate member of staff.				
Observe the condition of the patient throughout the measurement.				
Identify and responds immediately in the case of any significant changes in the Patient's condition.				
Recognises and reports without delay any measurement that falls outside of the normal range.				
HCA is aware of the importance or repeating patients observations within an hour to see if any interventions carried out have made an improvement.				

Direct Observation of Measurement of Vital Signs

You will be required to be observed carrying out at least 3 sets of observations on each age range in order to assess competence. If however you feel you would like more supervision please do not hesitate to ask.

PLEASE NOTE IT IS NOT ACCEPTABLE TO RECORD TEMPERAUTRE ONLY

0 – 4 weeks

0 – 4 weeks	Observation One		Observation Two		Observation Three	
	Date	Signature of Assessor	Date	Signature of Assessor	Date	Signature of Assessor
Temperature						
Pulse						
Respirations						
Effort of Breathing						
Oxygen Saturations						
Blood pressure						
AVPU						
Capillary Refill Time						
FLACC						
Sepsis Trigger						
PEWS Calculation						

1 – 11 Months

1 – 11 months	Observation One		Observation Two		Observation Three	
	Date	Signature of Assessor	Date	Signature of Assessor	Date	Signature of Assessor
Temperature						
Pulse						
Respirations						
Effort of Breathing						
Oxygen Saturations						
Blood pressure						
AVPU						
Capillary Refill Time						
FLACC						
Sepsis Trigger						
PEWS Calculation						

1 – 4 Years

1 – 4 years	Observation One		Observation Two		Observation Three	
	Date	Signature of Assessor	Date	Signature of Assessor	Date	Signature of Assessor
Temperature						
Pulse						
Respirations						
Effort of Breathing						
Oxygen Saturations						
Blood pressure						
AVPU						
Capillary Refill Time						
FLACC						
Sepsis Trigger						
PEWS Calculation						

5 – 12 Years

5 – 12 years	Observation One		Observation Two		Observation Three	
	Date	Signature of Assessor	Date	Signature of Assessor	Date	Signature of Assessor
Temperature						
Pulse						
Respirations						
Effort of Breathing						
Oxygen Saturations						
Blood pressure						
AVPU						
Capillary Refill Time						
FLACC						
Sepsis Trigger						
PEWS Calculation						

13 – 18 Years

13 – 18 years	Observation One		Observation Two		Observation Three	
	Date	Signature of Assessor	Date	Signature of Assessor	Date	Signature of Assessor
Temperature						
Pulse						
Respirations						
Effort of Breathing						
Oxygen Saturations						
Blood pressure						
AVPU						
Capillary Refill Time						
FLACC						
Sepsis Trigger						
PEWS Calculation						

Fluid Balance

Fluid balance is the accurate monitoring of a patient's fluid input and output in order to prevent either dehydration or over-hydration.
Fluid balance recording is often inadequate or inaccurate due to lack of training, lack of time or staff shortages. However it is not a difficult skill to learn.
Accurate monitoring of fluid input and output is important as fluid balance is an essential requirement for life and an indication of kidney function. Identifying poor fluid intake or output can help identify a deteriorating patient therefore if not completed or completed incorrectly could lead to adverse effects on health and in some cases death.
Assessing fluid balance consists of 3 elements:

1) Clinical assessment e.g. baseline observations, general appearance of child and capillary refill time (CRT).
2) Body weight
3) Accurate input and output

What are the components of fluid balance?

- Eating
- Drinking
- Passing urine
- Passing stools
- Vomiting
- Sweating

Dehydration can occur when your body loses more fluids thank you take in.
Causes of dehydration in children:

- Vomiting
- Diarrhoea
- Sore Throats
- Fever
- Respiratory illness
- Prolonged nil by mouth (NBM)
- Excessive blood loss
- Polyuria (increased urine output)
- Burns
- Medication

Fluid requirements:

- Well baby – 150mls/kg/day
- Minimum fluid requirement per day on a baby 100mls/kg per day unless otherwise indicated.
- Children over the age of 1 require 2-3 litres of fluid per day.

To calculate urine output you can measure volume in a jug/urinal bottle or by weighing nappies/pads. 1 gram in weight is equivalent to 1ml of fluid – please remember to minus the weight of the dry nappy or pad to give you an accurate figure.

Please ensure that on admission the fluid and dietary intake the child / young person has had over the last 24 hours is documented in the admission paperwork and on the fluid balance chart.

Fluid balance charts (Appendix 2) should be updated at least 4 hourly to ensure accurate monitoring of intake and output is carried out. If a patient is asleep this should be documented on their paperwork the chart should not be left blank. If we don't make a record of some description it means we didn't check or offer diet & fluids.

Worcestershire Acute Hospitals NHS Trust

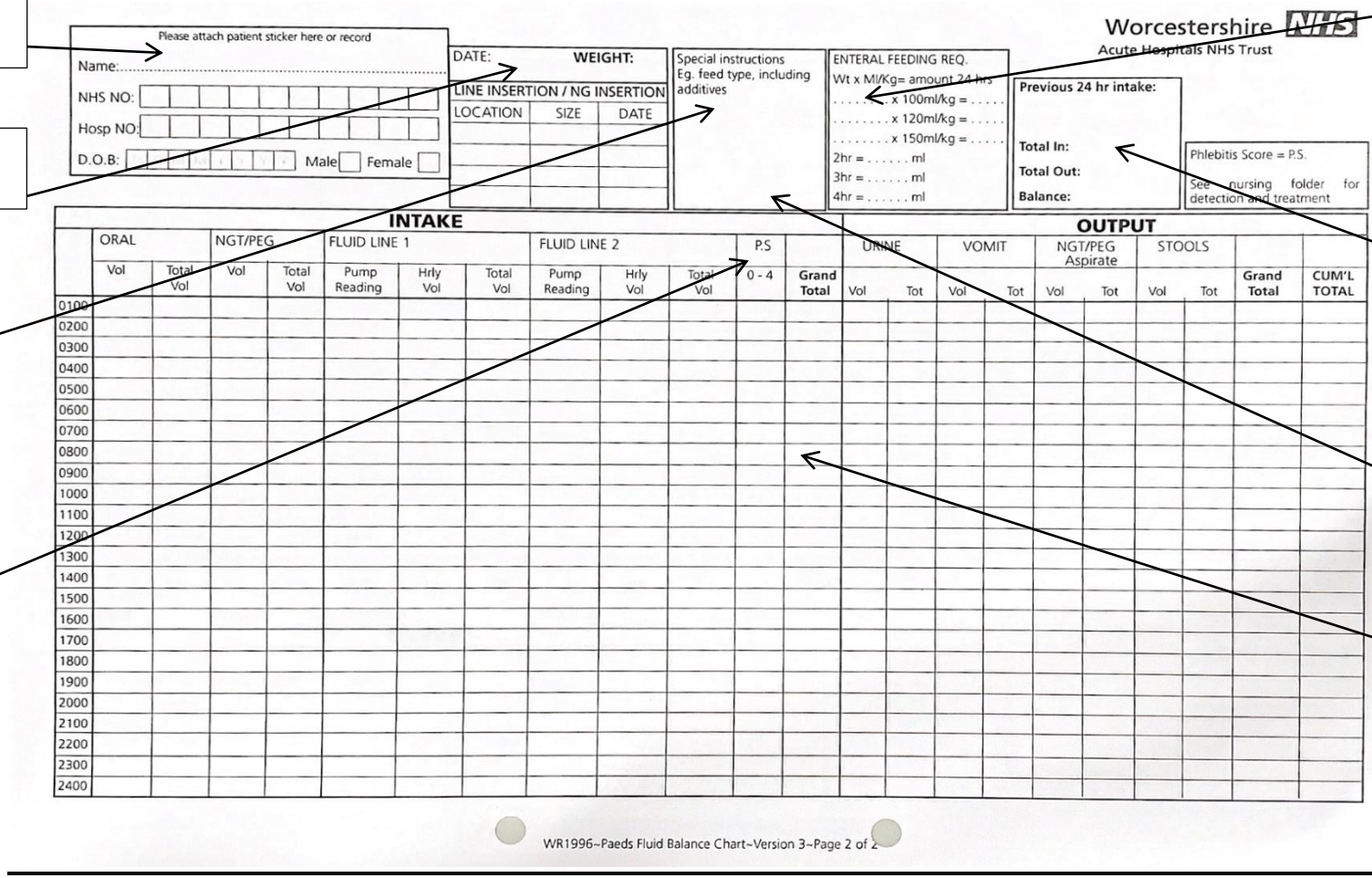
Fluid Balance Monitoring

Affix patient sticker – do not use stickers with address on.

Ensure date and patient weight recorded on each day

Record type of feed baby is on including any additives

If patient is on intravenous fluids please monitor & record phlebitis score hourly. Document phlebitis score when also giving IVAB.



Please attach patient sticker here or record

Name:

NHS NO:

Hosp NO:

D.O.B: Male Female

DATE: WEIGHT:

LINE INSERTION / NG INSERTION

LOCATION	SIZE	DATE

Special instructions Eg. feed type, including additives

ENTERAL FEEDING REQ.

Wt x Ml/Kg= amount 24 hrs

. . . . . x 100ml/kg = ...

. . . . . x 120ml/kg = ...

. . . . . x 150ml/kg = ...

2hr = ... ml

3hr = ... ml

4hr = ... ml

Previous 24 hr intake:

Total In:

Total Out:

Balance:

Phlebitis Score = P.S.

See nursing folder for detection and treatment

Worcestershire NHS Acute Hospitals NHS Trust

INTAKE

	ORAL		NGT/PEG		FLUID LINE 1			FLUID LINE 2			P.S	
	Vol	Total Vol	Vol	Total Vol	Pump Reading	Hrly Vol	Total Vol	Pump Reading	Hrly Vol	Total Vol	0 - 4	Grand Total
0100												
0200												
0300												
0400												
0500												
0600												
0700												
0800												
0900												
1000												
1100												
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1900												
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2200												
2300												
2400												

OUTPUT

	URINE		VOMIT		NGT/PEG Aspirate		STOOLS			
	Vol	Tot	Vol	Tot	Vol	Tot	Vol	Tot	Grand Total	CUM'L TOTAL
0100										
0200										
0300										
0400										
0500										
0600										
0700										
0800										
0900										
1000										
1100										
1200										
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2000										
2100										
2200										
2300										
2400										

WR1996~Paeds Fluid Balance Chart~Version 3~Page 2 of 2

Calculate fluid requirement here. Medical staff should indicate volume per kg required.

Record previous 24 hour fluid intake and output and cumulative balance here

If patient wears nappies record dry nappy weight here

Total all oral/NG or IV in-take here

Fluid Balance

The HCA has demonstrated that they:	Description of Evidence Required	Level of Achievement / Grade	Date	Signature of Assessor
Physiological / Theoretical Knowledge				
Understand the concept of fluid balance				
Is knowledgeable about their role, responsibility and accountability regarding fluid balance and accurate documentation of fluid balance				
Calculating Fluid Requirements				
Can identify the correct patient and is able to locate correct patient charts.				
Is able to accurately weigh the child in Kilograms (Kg)				
Is aware of how to calculate all output if required using mls as units.				
Documenting Fluid Balance				
Is aware of accountability and documentation requirements				
Is able to accurately document hourly volumes of oral fluids generating a total of oral fluids if required.				
Is able to document output in a quantifiable manner.				
Escalating Abnormal Fluid Balance				
Is able to identify an abnormal or worrying fluid balance result.				
Can identify immediate action that needs to be taken.				
Can escalate concerns clearly using SBAR to relevant member of the medical / nursing team.				
Ensures child and family are informed and updated about actions taken.				

Urinalysis & Specimen Collection

Urine testing or urinalysis is a valuable tool in assessing a patient. It provides valuable information about hydration, renal (kidney) function, diabetes and urinary tract infections.
The kidneys filter the blood and remove any waste products in the form of urine. Urinalysis is very easy to undertake but the results must be interpreted correctly to ensure any potential issues are identified and escalated to the medical team.

There are various different ways to obtain a urine sample. These are:

Bag catch urine – Used on babies and toddlers but these should ideally only be used if we need to test the urine for anything other than infection. A bag catch sample is not an accurate way of identifying a urine infection as it could pick up contaminants from around the child's skin. If you are trying to identify a urine infection DO NOT use a bag to obtain your sample.

Clean Catch urine sample (ideally mid-stream) – This is the preferable way to obtain a urine sample. The patient should have just been cleaned or washed and then the stream of urine should be caught in a sterile receptacle (kidney dish, jug, gallipot). For an ideal result the sample should be obtained mid-stream.

Catheter specimen – If an urgent urine sample is required then the medical team will obtain a urine sample by inserting a catheter, dependent on the child's condition as to if the catheter is left insitu or the majority of occasions the medical team will do an in/out catheter to obtain their sample.

When testing a urine sample the sample should be fresh (preferably less than 4 hours old).
When you have obtained a urine sample you should carry out a routine observation of the urine:
Colour – usually ranges from pale straw to deep amber depending on concentration (Steggall 2007).

- Dark urine – may indicate dehydration
- Brown / green or strong yellow may indicate presence bilirubin

- Green – may indicate presence of pseudomonas infection or excretion of cytotoxic drugs
- Bright red / red-brown may indicate presence of blood (haematuria). Menstruation should be ruled out in females.

Certain foods or drugs can also effect the colour; beetroot can produce a pinkish shade and rifampicin can turn urine an orange / red colour.

Clarity – This is usually referred to as clear, slightly cloudy, cloudy or turbid. Substances that can cause cloudiness but are not harmful include mucus, sperm and skin cells. Other substances that make urine cloudy are white / red blood cells, pus or bacteria. Frothy urine signifies protein in the urine.

Odour – Freshly voided urine may have a slight but inoffensive smell.

- Fishy smell / ammonia: may indicate a urine infection
- Pear drop / acetone smell: may indicate presence of ketones, as in diabetic ketoacidosis
- Some strongly flavoured foods can also produce an odour e.g. asparagus.

Carrying out urinalysis:

Prior to obtaining and testing a urine sample verbal consent should be obtained from the child / young person or their parent / guardian.

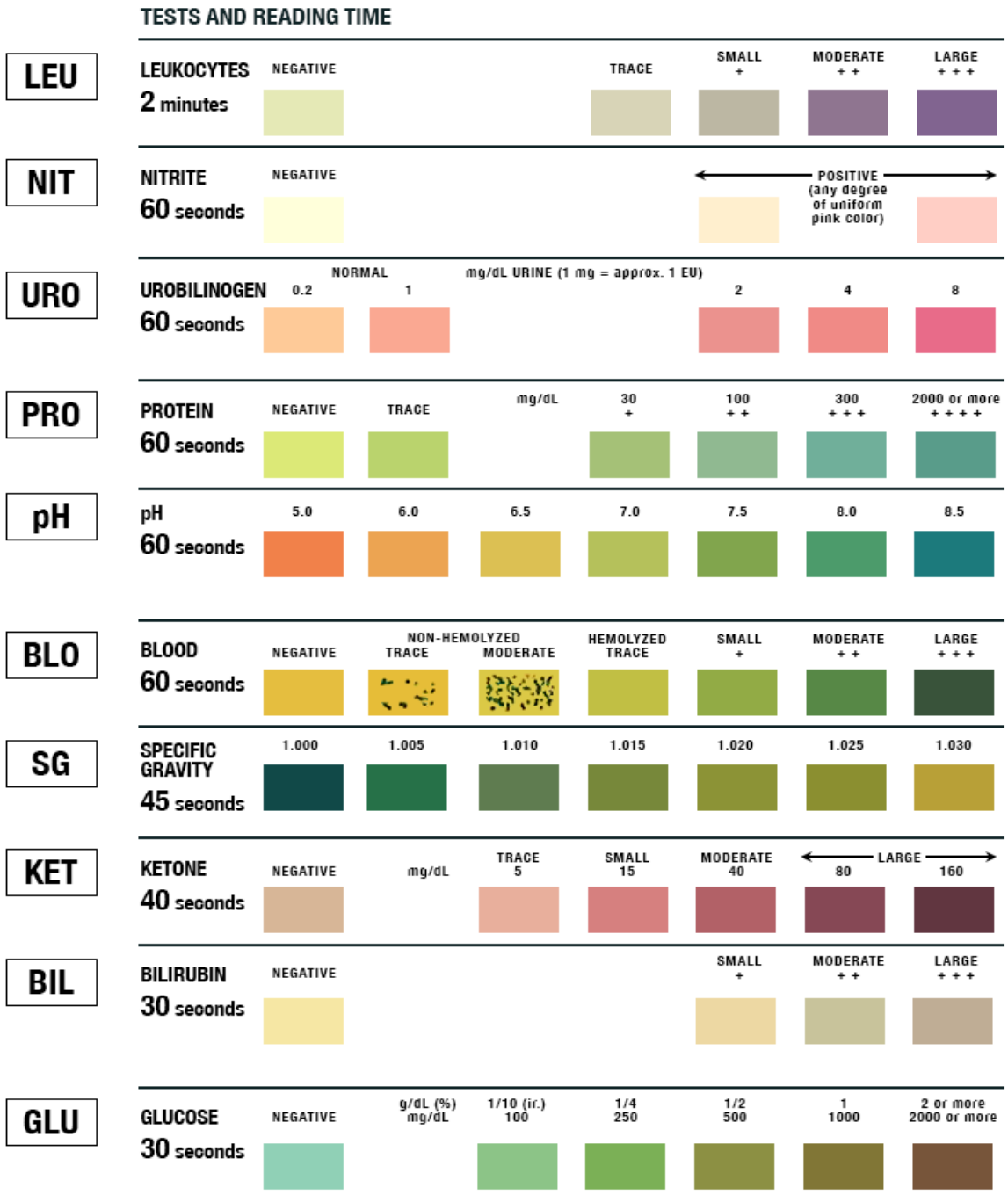
The test strips we use are Multistix all testing should be carried out in the sluice wearing appropriate PPE.

The sample stick should be fully immersed in the urine for approximately 2 seconds then removed and tapped against absorbent paper to remove any excess urine.

Urine test sticks test for:

- Glucose – wait 30 seconds before results are read
- Ketones – wait 40 seconds
- Specific Gravity (SG) (concentration of urine) – wait 45 seconds
- Blood – wait 60 seconds
- pH – wait 60 seconds
- Protein – wait 60 seconds
- Nitrites – wait 60 seconds
- Leucocytes – wait 120 seconds

Once you have waited the correct times the results can by analysed, please see chart below on how to interpret results.

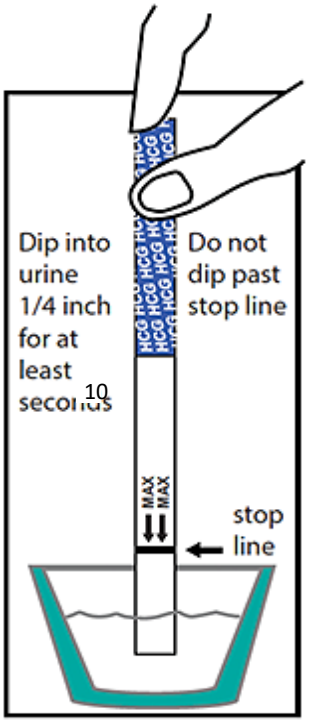


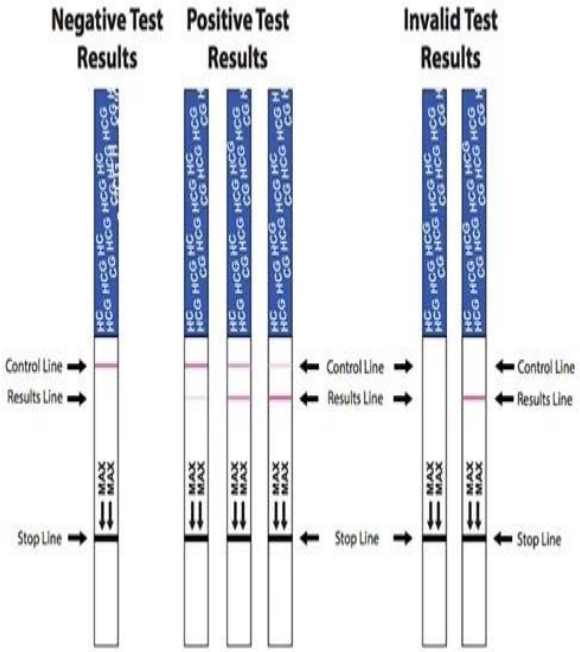
If any abnormalities are detected the sample should be kept in the correctly labelled sample pot and a trained member of nursing staff or a member of the medical team should be informed to ensure a correct diagnosis can be

reached, and the sample can be sent to the laboratory for testing in a timely manner.
An untreated or unidentified urine infection could lead to worsening condition and sepsis, so it is important to recognise and report any abnormalities when carrying out urinalysis.

Pregnancy Testing

If a female patient that has begun puberty presents and requires a urine sample to be obtained a pregnancy test may also need to be carried out. Please check with medical staff or the nurse caring for the patient. If a pregnancy test has been requested verbal consent MUST be sought from the patient or their parent / guardian this should be documented in the patients notes.
Please be aware that all female patients over 12 years of age that require surgery need to have a pregnancy test carried out prior to theatre.
Follow directions on the leaflet when carrying out a pregnancy test, all results should be checked by 2 members of staff (at least 1 x trained nurse).





On completion or urinalysis remove all PPE and dispose of in appropriate bin (Orange) and wash hands as per hand hygiene regulations.

Obtaining stool samples:

On occasion you may be asked to obtain a stool/faecal sample for a patient it must be collected at the right time using the right technique and equipment, correctly and clearly labelled with the correct patient details and should be delivered to the laboratories in a timely manner.
Appropriate PPE should be worn and hands should be washed as per hand hygiene policy.
Stool samples are usually required to identify any bacterial, viral or parasitic infection.
Bacterial:

- Salmonella
- Campylobacter
- C-Diff (Clostridium Difficile)
- E-Coli
- Shigella
- Helicobacter
- CPE

Viral:

- Norovirus
- Rotovirus

Parasites:

- Tapeworm
- Protozoa

When obtaining a stool sample the consistency of the stool should be noted using the Bristol Stool Chart as reference (see below) and the type should documented on the fluid balance chart.

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

Urinalysis and HCG Testing- Staff Competencies

Performance Criteria	Description of Evidence Required	Level of Achievement / Grade	Date	Signature of Assessor
Theoretical Knowledge				
• HCA Understands the concept of Urinalysis and HCG testing				
• HCA understands the indication for urine testing				
• HCA is aware of PPE and infection control measures when dealing with bodily fluids that need collecting				
• HCA aware of PPE when dealing with cytotoxic waste				
• HCA is aware of different urine collection methods - Clean catch - MSU - Catheter sample - Bag Catch				
• HCA is aware of when a HCG may be needed – correct age range.				
Performance Criteria	**Description of Evidence Required**	**Level of Achievement / Grade**	**Date**	**Signature of Assessor**
Practical Knowledge				
• HCA collects urine sample from patient in the most appropriate form.				
• HCA can decant urine into most appropriate container for analysis				
• HCA is able to sufficiently cover urinalysis dip stick and blot away any excess liquid				
• HCA is able to read accurately the urinalysis stack at appropriate time intervals to give accurate reading				
• HCA can put urine in to appropriate sample tube to send for further laboratory analysis if required				
• HCA is able to accurately carry out HCG test and need for result to be checked with a trained member of staff.				

Performance Criteria	Description of Evidence Required	Level of Achievement / Grade	Date	Signature of Assessor
Escalating and Reporting Findings				
• HCA can accurately report urine dip results using the indicated space on the Assessment Document and on the Results sheet on inpatient forms				
• HCA is able to identify any abnormalities and escalate to trained staff and/or medical team.				
• In the case of HCG testing. The test must be checked by a trained member of staff and this recorded				

Infant Feeding

Worcestershire Acute Hospitals NHS Trust believes that breastfeeding is the healthiest way for a woman to feed her baby and recognises the important health benefits now known to exist for both the mother and her child.

All staff at Worcestershire Acute Hospitals NHS Trust should understand their role and responsibilities in supporting new mothers and their partners to feed and care for their baby in ways which support optimum health and well-being. All staff caring for newborns and their parents will be educated to implement the baby friendly standards according to their role and the service provided.

All new staff should attend the Trust Infant feeding training within the first 6 months of commencing their role, this will be booked for you by the Infant Feeding link team on the ward.

Our aim is to create an environment where more women choose to breastfeed their babies, confident in the knowledge that they will be given support and information to enable them to continue breastfeeding exclusively for six months, and then as part of their infant's diet for as long as the mother and baby decide.

All mothers have the right to receive clear and impartial information to enable them to make a fully informed choice as to how to feed and care for their babies.

It is important as health care staff we do not discriminate against any woman in her chosen method of infant feeding and will fully support her when she has made that choice.

Responsive feeding

The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should ensure that mothers have the opportunity to discuss this aspect of feeding and reassure mothers that: breastfeeding can be used to feed, comfort and calm babies; breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoiled' by too much feeding and breastfeeding will not, in and of itself, tire mothers any more than caring for a new baby without breastfeeding.

Responsive feeding should be encouraged for all babies unless clinically indicated. Hospital procedures should not interfere with this principle. Staff will ensure that mothers understand the nature of feeding cues and the importance of responding to them and that

they have an awareness of normal feeding patterns, including cluster feeding and 'growth spurts'.

Mothers should be informed that it is acceptable to wake their baby for feeding if their breasts become overfull.

Use of Artificial Teats, Dummies and Nipple Shields while Breastfeeding

As health care staff we should not recommend the use of artificial teats and dummies during the establishment of breastfeeding. Parents wishing to use them should be advised of the possible detrimental effects such use may have on breastfeeding to enable them to make a fully informed choice. A record of the discussion and parents' decision should be recorded in the baby's notes.

Nipple shields should not be recommended except in extreme circumstances and then only for as short a time as possible. Any mother considering the use of a nipple shield must have the disadvantages fully explained to her prior to commencing use. Shields should never be suggested or used until the mother has an established milk supply.

Supporting parents who have chosen to feed their newborn baby with infant formula.

If parents have chosen to feed their newborn baby with infant formula it is important they are able to correctly sterilise equipment and make up a bottle of infant formula and should be supported in doing this by health care staff.

Parents who formula feed should be aware of the importance of responsive feeding and be encouraged to:

- respond to cues that their baby is hungry
- invite their baby to draw in the teat rather than forcing the teat into their baby's mouth
- pace the feed so that their baby is not forced to feed more than they want to
- recognise their baby's cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants
- understand the need to stay on the FIRST INFANT FORMULA (whey-based) and this is the only formula they will need in the first year of life

Practical skills review form: Breastfeeding and hand expression

Name:	Name of facilitator:	Date:

The practical skills review is part of your mandatory infant feeding training and needs to be done before your training is complete.

The purpose of the practical skills review is to give you the opportunity to practice discussing and demonstrating the practical skills of infant feeding in a safe environment and receive individual feedback. It also provides you with an opportunity to discuss any concerns or questions you may have about any aspects of your practice related to infant feeding on a one-to-one basis with a member of the infant feeding team. It is designed to be a supportive learning experience.

Your practical skills facilitator will give you verbal feedback on positive aspects as well as any areas for improvement that you may identify together. S/he will use the form to give you written feedback for your records.

To start the discussion you will either be asked to describe a recent situation in which you supported a mother with learning to attach her baby to the breast or given a scenario that is related to your role to discuss. The facilitator will have a doll and breast model and leaflets in use in your facility for you to use.

Supporting a mother and baby to achieve a successful feed		
Is the practitioner able to	***✓or X***	*Comments*
Describe an approach to teaching the practical skills of breastfeeding which demonstrates a mother-centred approach • Observing and listening • Hands off approach • Clear relevant information shared • Use of leaflets, analogies, props		
Identify signs of instinctive behaviour in baby (rooting, head bobbing, mouthing the nipple) and help mother to recognise them.		
Identify areas where additional information is needed and explain appropriately		
To include:		
Principles of positioning		
• Baby held close		
• Baby held/supported with head and body in line		
• Baby's head free to tilt back		
• Baby held with nose opposite nipple Or could use CHIN acronym		
Or, mother supports her baby in a way that allows self attachment (laid back, biological nurturing)		
The process of attachment		
• Watch for baby to have a wide open mouth		
• Mother moves her baby to her breast, with his head tilted back and chin leading		

• Bottom lip touches breast well away from the base of the nipple and nipple aimed towards the rear of the roof of the baby's mouth		

Is the practitioner able to	✓ *or X*	*Comments*
Observe signs of effective feeding		
• Mother comfortable during feed – suckling does not cause pain		
• Baby's mouth is wide open		
• Baby's chin indents the breast		
• Baby's cheeks are full and round		
• Suckling is appropriate to age of baby (usually rapid initially, then deep and rhythmic with pauses and audible swallows)		
• Areola – if any is visible then more will be visible above the baby's top lip		
• The baby is contented and stays on the breast		
Show a mother how to hand express		
Explain why hand expressing might be useful and describe when she uses this skill in her current role		
Describe an approach to teaching the practical skills of hand expressing which demonstrates a mother-centred approach (see above)		
Describe or show using a diagram or model the relevant anatomy		
Explain the importance of stimulating oxytocin to flow and suggest things that will help this process e.g. Having skin to skin contact, rooming in and breast massage/use of something to remind mother of baby		
Explain to a mother how she will find the right spot for her to put her fingers and express milk • Place fingers 2-3 cm back from the base of the nipple *(understands the importance for the mother of having a go an shifting her fingers a little until she finds what works for her)*		
Explain the technique of expressing • Place finger(s) and thumb in a C shape, opposite each other • Compress and release in a steady rhythm (+/- pressing back first) • Avoid sliding fingers on skin • Move round breast once flow slows • Once flow slows/ceases move to other breast		

Practical skills review form: Responsive bottle feeding

Name:	Name of facilitator:	Date:

The purpose of the practical skills review is to give you the opportunity to practice discussing and demonstrating the practical skills of infant feeding in a safe environment and receive individual feedback. It is designed to be a supportive learning experience.

Your practical skills facilitator will give you verbal feedback on positive aspects as well as any areas for improvement that you may identify together. S/he will use the form to give you written feedback for your records.

To start the discussion, you will either be asked to describe a recent situation in which you supported a mother with learning to bottle feed her baby safely and responsively or demonstrate using a doll.

Responsive bottle feeding – preterm baby		
Is the practitioner able to	***✓or X***	*Comments*
Describe the benefits of responsive bottle feeding: • Encourages a close and loving bond between mother and baby • Stimulates hand-eye coordination • Facilitates social interaction • Reduces the likelihood of over-feeding (which may lead to obesity) • May reduce risk of aspiration		
Describe early signs of hunger and feeding cues: *NB – these may be more subtle in a preterm baby* • Baby turning the head and opening the mouth (rooting). Bringing the hands to the mouth/sucking the fist or fingers • Sticking out the tongue • Agitation/crying (late hunger signs)		
Describe positioning and preparation of the baby for bottle feeding: • Baby should be quiet but alert • Calm an upset baby (skin-to-skin contact is ideal for this) – feeding should be a positive and comforting experience • Help baby to feel secure by cradling him/her close and in a slightly upright position, enabling the hands to come to the midline (important for the development of motor and cognitive skills) • Side-lying: Head higher than the hips, ideally facing you to enable stress signs to be		

picked up • Maintain head position in the midline • Look into the baby's eyes and gently talk to him/her		
Discuss pacing of a bottle feed: • Invite the baby to take in the teat by gently touching the top lip with it and allowing him/her to draw it in • Allow just enough milk to cover the teat and let the baby control the feeding pace, removing the teat if baby shows he/she needs a break to encourage self-regulation behaviours • Offer frequent breaks throughout the feed, sitting baby upright to help bring up wind • Do not turn the teat whilst in the mouth or passively hold the jaw • Never force the baby to take a whole feed		
Describe signs of stress during bottle feeding: • Yawning or drowsiness • Colour change/O2 desaturation • Nasal flaring • Tachypnoea • Pushing the teat out with the tongue • Agitation/turning the head away • Gulping milk/gasping • Milk pouring from the sides of the mouth • Widening of the eyes (startled look) • Splayed hands		

Nasogastric Tube Feeding

It is important to monitor a child or young persons fluid and diet intake to ensure adequate hydration. In some cases a child may be unable to manage diet and fluids orally either due to their underlying condition or just for an acute period while they are unwell. Therefore the child may need support with their hydration and calorie intake. Intravenous fluids can be used for a short period but they only maintain hydration and maintain electrolyte levels. To ensure calorie intake is maintained we can feed a patient enterally. This involves passing a nasogastric (NG) tube down their nose and into their stomach (see fig.1).

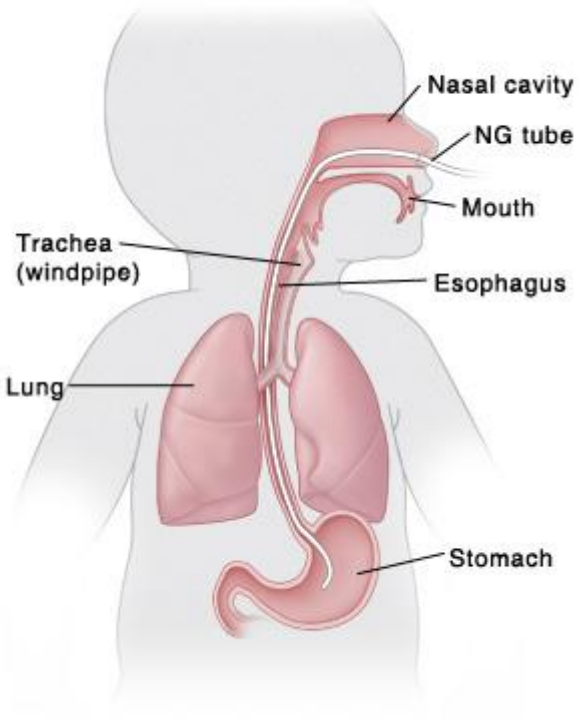


Fig 1.

A nasogastric tube is a plastic tubing that allows delivery of nutritionally complete feed directly into the stomach. The decision for the need of a nasogastric tube should be made a trained professional and the patient should meet a certain criteria.

NICE guidelines state that nasogastric tubes should only be used in patients who are malnourished or at risk of malnutrition.

Indications for a nasogastric tube:

- Feeding purposes –

    1. Bronchiolitis – babies with bronchiolitis may have difficulty feeding therefore may require nasogastric tube feeding to maintain their nutrition throughout their admission.

2. Jaundice, poor weight gain/feeding – some babies may require nasogastric tube feeding following birth in order to help establish feeding. Jaundice can make babies very sleepy and they are unable to feed therefore they may require their nutrition via a nasogastric tube for a short period.

3. Underlying condition – some children may have an underlying condition (cerebral palsy, cardiac) that prevents them from being able to feed orally therefore may require nasogastric tube feeds.

4. Mental Health – occasionally some young people may develop a mental health illness which can become so severe that they require nutrition via a nasogastric tube.

- Administration of Medication –

    1. Some children may require a large number of medications which they struggle to take orally, therefore a nasogastric tube may be required to help aid medication administration.

- Removal of gastric contents –

    1. Bowel obstruction – If a patient has a suspected bowel obstruction or ileus a nasogastric tube should be passed to provide bowel rest. The tube should be on free drainage or aspirated regularly.

Nasogastric tubes should only be passed by staff who are trained to pass a tube, misplacement of an NG tube can lead to aspiration, infection and potentially death.

Below is a picture of the type of nasogastric tube in use on the ward. They can remain in situ for up to 90 days (please refer to manufacturers information regarding duration tube can be left insitu (See Fig. 2).

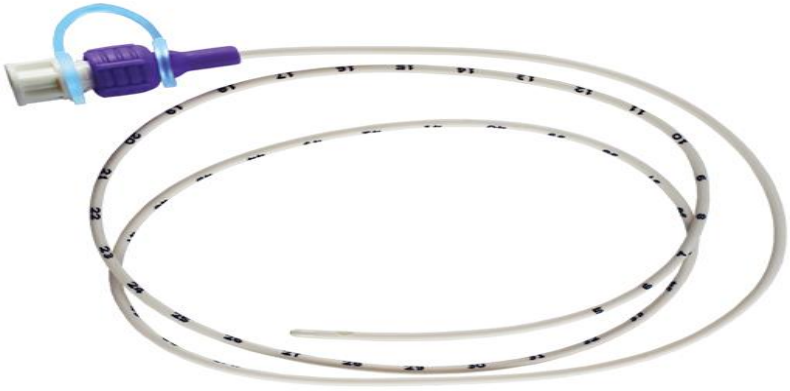


Fig. 2

Prior to using a nasogastric tube you must ensure you are wearing appropriate PPE. The patients face should be monitored to ensure skin and nostril are intact there is no sign of tissue damage from where the tube is sitting. The tape securing the tube should be checked to ensure the tube is secure, clean and undamaged. The patient should be in an elevated position approximately a 45 degree angle.

Hands should be washed in accordance with the hand hygiene guideline prior to accessing an NG tube.

All equipment needed should be prepared in advance:

- PPE
- 50ml enteral syringe (purple)
- pH paper
- Feed set – gravity or pump set
- Feed at correct temperature
- Sterile water
- Syringe to flush post feed

Consent should be obtained prior to accessing the tube from the patient or parent/guardian.

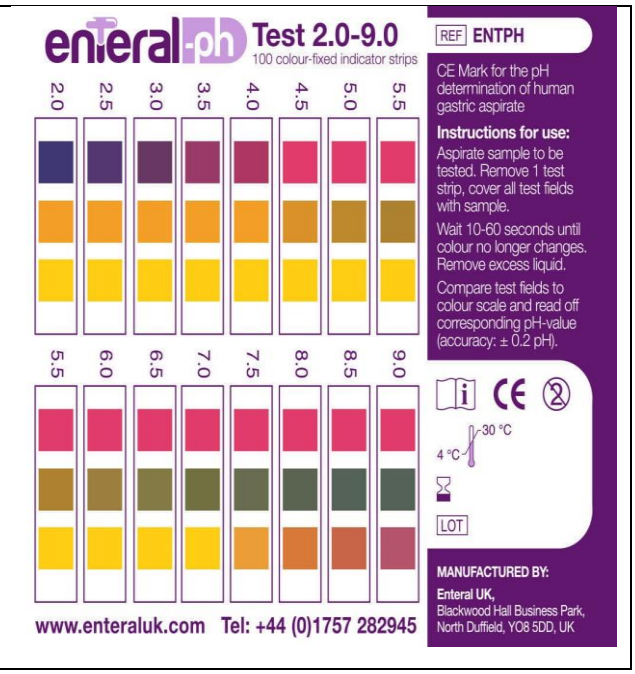
Once ensuring the tube is intact, tapes are secure, all equipment is prepared and the patient is in the correct position you can start the process to feed the patient.

It is VERY important the position of the NG tube is checked prior to starting any feed to ensure the tube has not become displaced. To do this you should first check the position at the nostril. The tube has measurements on and when the tube was passed the length should have been documented in the patients bedside folder this should be checked before EVERY feed. Once you have confirmed you are happy with the length of the tube you need to check it is still in the stomach. To do this you need a 50ml enteral syringe and some pH paper. Attached syringe to the end of the NG tube and aspirate (pull back) a small amount from the tube, this should then be applied to the pH test strip

and the results should be compared against the readings on the pH strip bottle.

Testing the aspirate from the tube is testing for the presence of stomach acid therefore ensuring the tube is still in the stomach so the tube is then safe to use. The pH reading should be between pH of 0 – 5. If the reading is any higher than a 5 then **DO NOT** use the tube and inform a nurse or member of the medical team (See Fig. 3).

Fig. 3



Once you are happy that the tube is still in the right position with a pH of 5 or less then the feed can be commenced.
Feeds should be calculated by a trained member of staff to ensure the child is receiving the correct fluids and calorie intake.

Feeds can then be given either by gravity syringe feed (Fig. 4) or via a pump (Fig. 5).

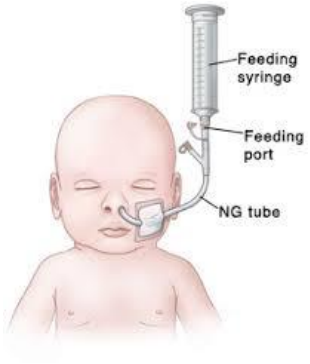


Fig. 4

A gravity feed is when an open syringe with the plunger removed is filled with formula that flows into the stomach by gravity. When doing a bolus feed via gravity, the higher you hold the syringe above the child, the faster it will flow. To slow the rate of flow, lower the syringe so it is closer to the child's stomach. If you hold the syringe below the level of the stomach, or if your child arches or coughs, formula may back up into the syringe. Simply raise the syringe to reverse the flow.

Feeding Pump: Some patients require bolus feedings or continuous feeding using a feeding pump, the dose can be set and delivered over a longer period of time which can help the child tolerate the feed better.

Fig. 5

Please complete the Nutricia Flocare Infinity pump training at:
www.nutriciaflocare.com

On completion of the feed the nasogastric tube should be flushed with sterile water, an appropriate amount should be used according to the size of the tube and the size of the child. Some patients require a large volume of flush at the beginning and end of their feeds but this should be documented on their feeding regime.

Once the feed has been given it needs to be documented in the patients bedside folder. The fluid balance chart should be updated and running total for the day calculated and the nasogastric tube feed record sheet should be completed (Appendix 3).

QUESTIONS FOR PAEDIATRIC NASOGASTRIC COMPETENCIES

Section 1

Understand reason for nasogastric feeding tube

Q – What is a nasogastric (NG) tube?

_____

_____

Q – How do you know what size the NG tube is?

_____

Q - **Q** – How long can the nasogastric tube stay in for?

_____

Q – Why may a baby/child need nasogastric feeding?

_____

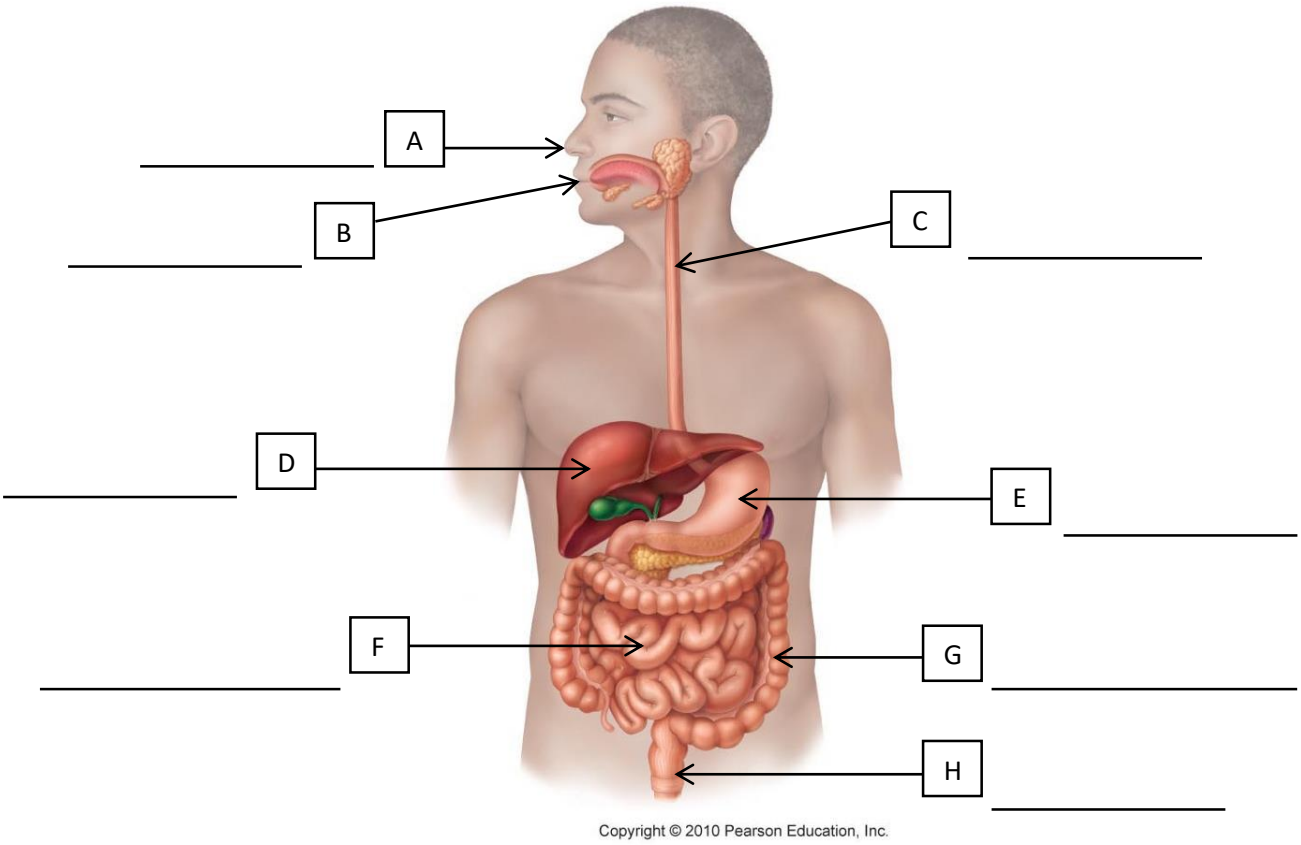
Q – Can a baby / child feed orally if they have an NG tube insitu?

_____

Q – When may it not be possible for a child to have oral feeds?

_____

Q – Please label the diagram below and match up the bodily function to the correct organ / body area.



☐ Re-absorbs water and salts and gets rid of any waste products.

☐ Produces bile and filtrates blood to remove toxins. Metabolises fats, proteins, carbohydrates.

☐ Waste products are excreted from here.

☐ Used for breathing, speech, and eating and chewing.

☐ Uses acid to digest food and fluids.

☐ Used primarily to breathe. The NG tube is passed through here, to the back of the throat and into the stomach. It will be taped to the cheek to keep it in place.

☐ Links the mouth to the stomach.

☐ Absorbs nutrients and minerals from food using enzymes secreted from the pancreas.

Section 2

Carer to understand psychological aspects of feeding a child with a nasogastric tube

Q - How can we try to prevent babies / children from developing an aversion to foods and fluids?

_____

_____

Q - What kind of mouth games can we play to encourage mouth movement?

_____

_____

Q – How can we ensure that babies / children's mouth stays healthy?

_____

_____

Section 3

Carer to understand psychological aspects of feeding on the family

Q – List some ways in which nasogastric feeding may impact on family life?

_____

_____

_____

_____

Section 4

Carer to understand the safety aspects of feeding

Q – Why is handwashing important? How do we safely wash our hands?

_____

_____

Q – When should we wash our hands during the feeding process?

_____

_____

Q – How can you get supplies for the nasogastric feeds?

Q – Where can you store the equipment and feed?

Q – How can you assess whether a feed or medicine is safe to use?

Q – What is important to check before you start any feed?

Q – What is the desired position for the baby / child to be in whilst they are being fed and for up to 30 minutes afterwards?

Q – How else can you reduce the risk of infection and contamination whilst preparing and giving a feed?

Section 5

Carer to demonstrate understanding of importance of checking tube position

Q – What do we need to definitively check before starting a nasogastric feed?

Q – How do you check the tube? What equipment do you need?

Q - When is it deemed unsafe to use a nasogastric tube?

Q – What should you do if you do **not** get the required result?

Q – Why might you not be able to get a required result when testing the tube?

Section 6

Carer to be competent using equipment required

Q - List the equipment that you will need for a nasogastric feed?

Q – How do you find out how a baby / child has their feeds?

Q – How do you know how much and what feed a baby / child has?

Q – How do you know what time the feeds are due?

Q – Why do we flush the tube?

Q - How do we prepare a flush?

Q - How do you know how much each baby / child has as a flush?

Q – How would you assess whether a baby / child needs extra hydration?

Q – How would you dispose of the equipment?

Section 7

Carer to be competent with daily care of tube

Q – How do we care for the tube and protect the skin around it?

Q – How can we tell if the skin is irritated?

Section 8

Carer to be aware of potential problems and solutions

Q – What are potential hazards of nasogastric feeds?

Q – What would you do if you suspect the tube becomes blocked or has become dislodged?

Q – What might lead you to believe the tube is not in the correct position?

Q – What would you do if a baby / child starts having vomiting and/or diarrhoea or abdominal discomfort.

Q – Who would you inform?

Section 9
Carer to show awareness of importance of record keeping

Q – What do you understand by accurate and appropriate documentation?

Q – Who can you share confidential information with?

Section 10
Carer to demonstrate awareness of issues of privacy and dignity

Q – Explains what privacy means to you

Q – Explain what dignity means to you

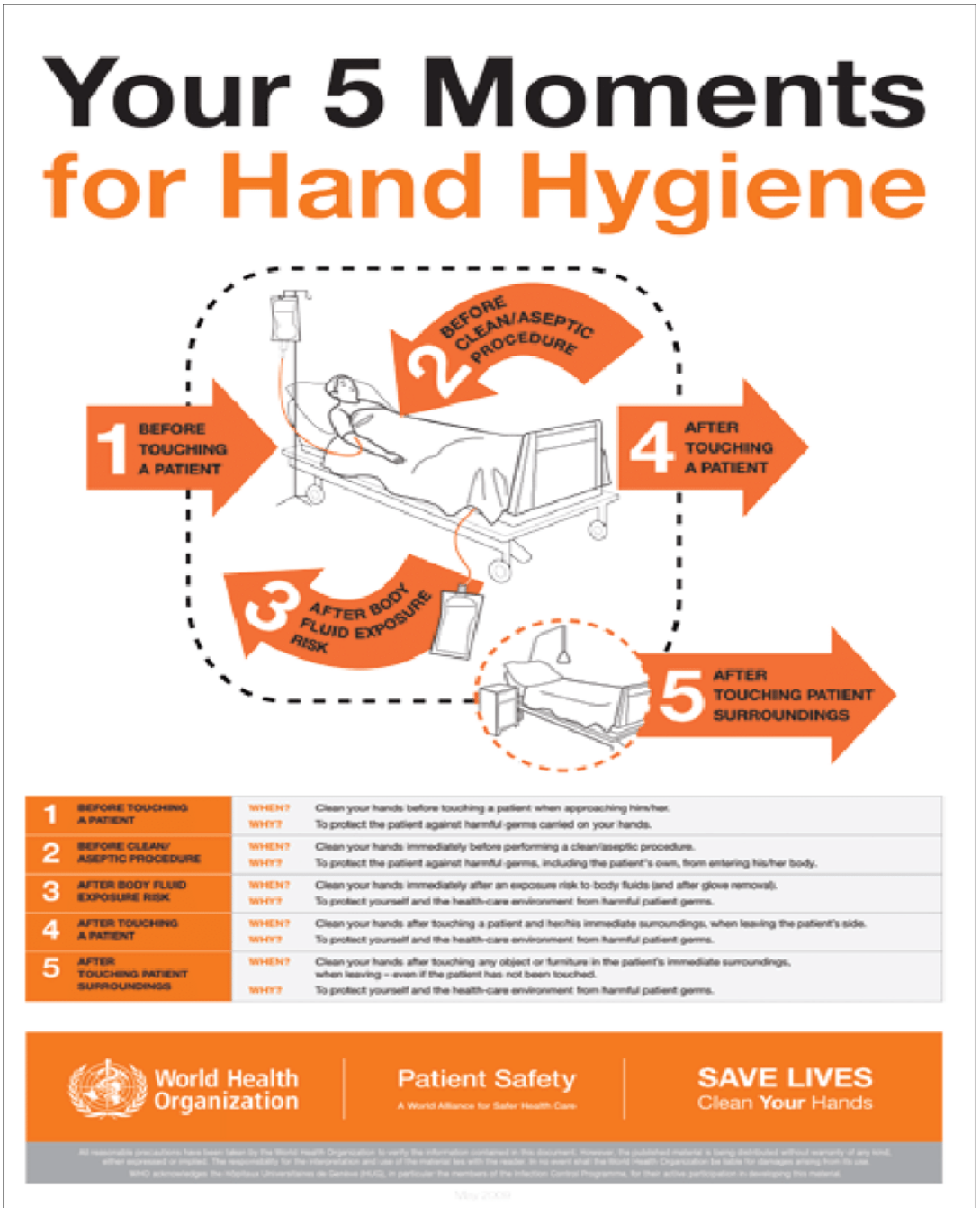
Q – How can we ensure the baby /child has privacy and dignity when they are being fed via the tube?

Questionnaire assessed by:

Name: _____

Role: _____

NMC number _____



NEONATAL AND PAEDIATRIC NASOGASTRIC TUBE FEEDING COMPETENCY FRAMEWORK

Can be used alongside 'Questions for Paediatric Nasogastric Competencies'

Staff name: _____

PERFORMANCE CRITERIA	**OBSERVED COMPETENCIES** *(Assessor to date and sign)*					
	Initial explanation and training.	**Practical training**	**First observed practice**	**Second observed practice**	**Third observed practice**	**Competent to teach others (if applicable)**
1. Understands the reason for nasogastric (NG) feeding tube. Can demonstrate an awareness of:						
1.1. The anatomy and physiology of the gastro-intestinal tract and the position of the NG tube						
1.2. The indications for NG tubes						
1.3. Any additional complications that infants / children may have that may complicate feeding, i.e. reflux, cleft palate, etc.						
2. Understands the psychological aspects of feeding a child with a NG tube Can demonstrate an awareness of:						
2.1. The importance of oral stimulation and prevention of food aversion, i.e. positive oral experiences, mouth games, dummy, finger foods, etc.						
2.2. The importance of maintaining oral hygiene						
2.3. Encouragement of interaction and involvement at mealtimes						
3. Understands psychological aspects of feeding on the family Can demonstrate an awareness of:						
3.1. The loss of the 'feeding role' on the family						
3.2. The impact of the nasogastric feeding on family life and management outside of the home						

	Initial explanation and training.	Practical training	First observed practice	Second observed practice	Third observed practice	Competent to teach others (if applicable)
4. Understands the safety aspects of nasogastric feeding Can demonstrate an awareness of:						
4.1. The importance of handwashing and demonstrates safe handwashing technique						
4.2. Safe storage of feed and equipment, i.e. sterile / unsterile, where to store, duration of storage.						
4.3. Safely checking correct feed, expiry date, look and smell of feed, rate of feed (if applicable) – checked and signed by 2 practitioners						
4.4. The correct positioning of the child during and after a feed						
4.5. The importance of checking the tube position prior to feeding and administering medicines – ensures at correct position at nose and tube is secure prior to feeding						
5. Demonstrate understanding of correct tube position Can demonstrate an awareness of:						
5.1. How to test for acid reaction using pH indicator paper						
5.2. Identifying the correct and safe pH reading for correct tube placement. A pH of 5.5 must be checked and documented by 2 registered practitioners to be safe to use.						
5.3. The knowledge of the guidelines for the safe testing and usage of the nasogastric tube (when it's safe / unsafe to feed)						
5.4. Steps to take if acid reaction not obtained						
5.5. Reasons why acid reaction may not be obtained						
6. Demonstrates safe and competent use of equipment Can demonstrate an awareness of:						
6.1 Checking equipment for integrity / sterility and placed within reach						
6.2 How to give a bolus NG feed (if appropriate)						
6.3 How to set up a feed via the pump (if appropriate). Online training can be accessed via the Flocare website						
6.4 Flushing of the tube before and after feed / medication; if applicable, as specified in the child's care plan. Taking into consideration fluid chart / balance						
6.5 Policy for waste disposal						

	Initial explanation and training.	Practical training	First observed practice	Second observed practice	Third observed practice	Competent to teach others (if applicable)
7. Competent with daily care of the nasogastric tube Can demonstrate an awareness of:						
7.1. Cleaning requirements and skin care						
7.2. Assessment and management of skin integrity / signs of skin irritation						
8. Aware of potential problems and solutions Can demonstrate an awareness of:						
8.1. Recognition of incorrect tube placement and risk of aspiration						
8.2. What to do if tube is blocked or dislodged						
8.3. What to do if child develops vomiting, diarrhoea, abdominal discomfort, etc.						
8.4. Escalates appropriately and to the right people						
9. Awareness of importance of accurate record keeping Can demonstrate an awareness of:						
9.1. Accurate, appropriate documentation						
9.2. Who to report to – Datix any incidents or adverse events						
10. Awareness of issues of privacy and dignity Can demonstrate an awareness of:						
10.1. Child and family confidentiality						
10.2. The child / young person's wishes and how they express them						
10.3. Understanding of issues for the patient and those around						

Competency achieved

Candidate *(please print):* _____ Assessor *(please print):* _____

Signature: _____ Date: _____ Signature: _____ Date: _____

(NB: Assessor must be a registered practitioner who has been assessed and is currently competent to perform the procedure)

Play Therapy & Distraction

Play is accepted as vital to healthy growth and development and a natural part of childhood which enables children to explore and make sense of the world they live in. For children and young people who undergo medical and surgical procedures, access to play carries greater significance.
Health play specialists use play as a therapeutic tool for children and young people who are in-patients or out-patients in hospitals, hospices and other community settings.
Play in hospitals has been developing since the mid 1960's with no specialist training available for the staff employed in the role. Today, qualified and registered play staff hold the professional title of Health Play Specialist (HPS).
Play has a special function in the healthcare environment, however play specialists are neither play therapists or play leaders.
Play specialists work with children of all ages and conditions and their work involves:

- organising daily play services in the playroom or at the bedside
- providing play to achieve developmental goals
- helping children deal with fear and anxiety
- using play to prepare children for hospital procedures such as injections or operations
- helping children cope with pain
- helping children regain skills lost through the effects of illness or hospitalisation
- supporting families including siblings
- contributing to clinical judgements through documentation and through their observations
- advising parents, carers and staff on appropriate play for sick and injured children

They are part of a multi-disciplinary team including speech and language therapists, occupational therapists, physiotherapists, psychologists, dieticians, specialist nurses, teachers, doctors and nurses.

Healthcare Play Specialist Education Trust (2021)

It is crucial for all staff to be aware of the importance of play when caring for children. Having an awareness of the use of distraction techniques can help prevent a child from becoming distressed and can help build trust.

CAMHS

What is CAMHS?

CAMHS stands for **Child and Adolescent Mental Health Services**. CAMHS is the name for the NHS services that assess and treat young people with emotional, behavioural or mental health difficulties.

CAMHS services generally support young people experiencing:

- sadness, low mood or depression
- feelings of worry or anxiety
- low confidence
- problems with eating or relationship with food
- anger
- problems sleeping
- hearing voices or seeing things
- thoughts about wanting to hurt yourself
- difficult feelings after a traumatic event.

CAMHS teams can offer support and treatments, like:

- **talking therapies -** to explore feelings – this might be on their own with a therapist or with their family there too
- **medication -** to help children and young people cope with how they feel
- **staying in hospital -** for further assessment treatment and support

There are local NHS CAMHS services around the UK, with teams made up of nurses, therapists, pyschologists, child and adolescent psychiatrists (medical doctors specialising in mental health), support workers and social workers, as well as other professionals.

The majority of CAMHS patients are treated and supported in the community by specially trained CAMHS team. However at times it may be necessary for patients to be admitted to hospital for further assessment and management of their condition. In some instances they may require more support in a specialised inpatient CAMHS unit (Tier 4) if it is deemed that the risk to

themselves is too great (Fig. 6). These patients may require 1:1 supervision on the ward by a member of ward staff or by a registered Mental health Nurse.

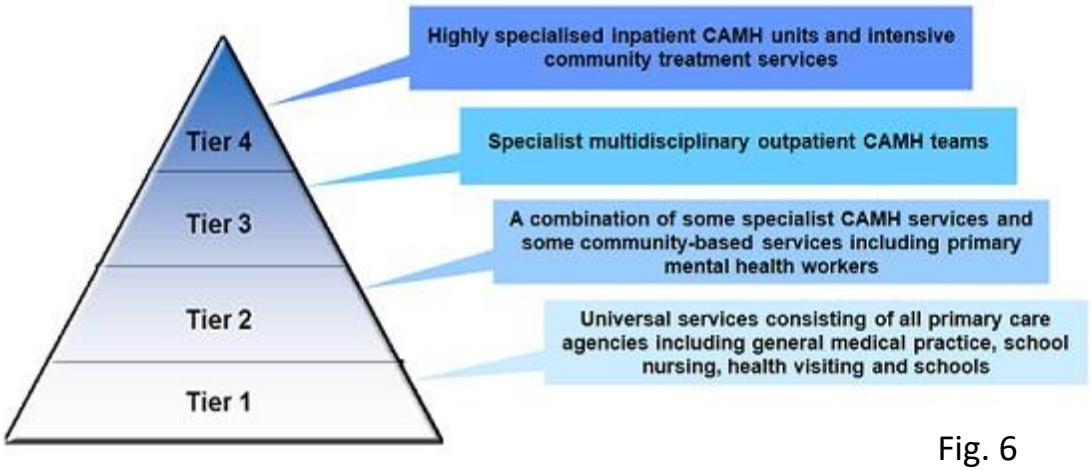


Fig. 6

We care for a number of patients who fall under the CAMHS category. It is important for these patients to be assessed by a trained professional on admission to the unit to determine the level of risk they pose to themselves or others.

In order to make an assessment of the child or young person's level of risk we use Mental Health Triage Tool (Appendix 4).

Once the Mental Health Triage Tool has been completed it will colour code the level of risk as blue to red, the triage tool then advises how frequently the patient should be observed and therapeutic observations should be commenced.

It is important at the beginning of each shift to document what the patient is wearing including hair style etc, as unfortunately these children are at high risk of absconding and therefore it enables ward staff, security or police to have an accurate up to date description of the child/Young Person.

Worcestershire Acute Hospitals NHS Trust

CAMHS TRIAGE TOOL COMPETENCIES

Performance Criteria	Description of Evidence Required	Level of Achievement / Grade	Date	Signature of Assessor
1. Theoretical Knowledge				
1a) Professional understands the concept of the CYP Mental Health Triage Scale	**D/Q**			
1b) Professional is knowledgeable about observed behaviour	**D/Q**			
1c) Professional is knowledgeable about reported behaviour	**D/Q**			
1d) Professional is knowledgeable about assessing level of risk using the CYP Mental Health Triage Scale	**D/Q**			
1e) Professional is able to demonstrate knowledge of action to be taken following risk assessment.	**D/Q**			
1f) Professional is aware of further considerations to be taken into account	**D/Q**			
1g) Professional can demonstrate referral process to AMHLS and CAMHS	**D/Q**			
1h) Professional understands the concept of therapeutic observations	**D/Q**			

1i) Professional is aware of the ward's ligature environmental risk assessment and those CYP categorized at yellow, orange and red should be assigned to CAMHS Room 19. If there is more than one CYP at this category, consideration should be given to co-horting with supervision if appropriate and documenting outcome and actions of risk assessment in medical records	**D/Q**			
1j) Professional is aware that when anti-ligature scissors are required the Tuff Cut scissors for this use can be found on ward Resuscitation trolley	**D/Q**			
1k) Professional is aware of Section 5(2) and how this can be applied in order to maintain safety of CYP should they attempt to abscond	**D/Q**			
1l) Professional is aware that the CYP will be the responsibility of an allocated RN Child, even when an RMN is present.	**D/Q**			
2. Performing Basic Assessment using CYP Mental Health Triage Scale				
2a) Professional is able to identify correct **level of risk** using the **CYP Mental Health Triage Scale** of observed and reported behaviours	**O/P Q D**			
2b) Professional is able to correctly document level of risk using CYP Mental health Triage Scale	**O/P Q D**			

	Description of Evidence Required	Level of Achievement / Grade	Date	Signature of Assessor
2c) Professional is able to demonstrate the correct frequency of therapeutic observations required based on identified level of risk.	**O/P Q D**			
2d) Professional ensures an explanation of the intended frequency of therapeutic observations is conveyed to the Child Young Person and family.	**O/P Q D**			
2e) Professional is able to accurately complete **therapeutic** observations in accordance with the assessment of the CYP Mental Health Triage Scale.	**O/P Q D**			
2f) Professional is aware that whilst they can increase frequency of therapeutic observations in accordance with level of risk identified, they cannot decrease frequency until CYP is formally reviewed by Tier 3+ CAMHS or member of AMHLS	**O/P Q D**			
2g) Professional documents general description of CYP and the clothes they are wearing should they abscond.	**O/P Q D**			
3. Escalation of increased level of Risk				
3a) Professional can identify any increase in risk level through CYP Mental Health Triage Scale	**O/P Q D**			
	Description of Evidence Required	**Level of Achievement / Grade**	**Date**	**Signature of Assessor**

3b) Professional is aware of how to escalate concerns via the nurse in charge, hospital co-ordinator and capacity hub (in hours and out of hours).	**O/P Q D**			
3C) Professional is aware that Security and Police can be informed to ensure safety of the CYP or other members of the ward i.e. patients and staff.	**O/P Q D**			
3c) Professional accurately documents their concerns, the escalation route taken and outcome.	**O/P Q D**			
3d) Professional documents RMN availability (if triggering Orange / Red) and if they are not available who is providing one to one supervision	**O/P Q D**			
3e) Completion of care plan to reflect level of care given.	**O/P Q D**			
3f) Professional demonstrates knowledge of Worcestershire CYP Multi-Agency Urgent Mental Health Care Pathway	**O/P Q D**			
3g) Professional is aware of the role and availability of CAMHS Tier 3+, AHMLS and Crisis Team	**O/P Q D**			

Consent

Consent to treatment means giving permission to medical treatment, test or examination.

Young people over the age of 16 years, are presumed to have enough capacity to consent to their own treatment, unless there is obvious evidence to suggest otherwise.

Children under the age of 16 years can consent to their own treatment if they are deemed to have a full understanding of what is involved in the treatment, and the risks associated with it. This is being known as Gillick Competent.

If they lack understanding then someone with parental responsibility can give consent, this could be:

- Child's mother or father
- Child's legally appointed guardian
- Person with a residence order over the child
- The local authority assigned to the child's care
- The local authority or person with an emergency protection order over the child

If a Gillick Competent child refuses treatment, then someone with parental responsibility (as listed above) can consent in their place.

Who Can Consent?

	Consent	Consent of others	Best interests	Refuse
Adults				
Competent	Yes – consent is the only basis on which treatment can happen	No – nobody else can give consent on behalf of a competent adult	No – A competent adult's best interests are irrelevant	Yes – Refusal may be rational, irrational or groundless
Incompetent	No – No incompetent person can give consent	Yes – Courts can consent on behalf of an incompetent adult	Yes – An incompetent adult can be treated in their best interests	No – No incompetent person can withhold consent
16 & 17 year olds				
Competent	Yes – without the need for consent with someone that holds parental responsibility	Yes – Person with parental responsibility, High Court jurisdiction, specific issues order	Yes – Welfare of child is court's main consideration (Children's Act), but court's authority in needed	No – Competent minor who withholds consent can be overruled by court or person with parental responsibility
Incompetent	No – No incompetent person can give consent	Yes – Person with parental responsibility, High Court jurisdiction, specific issues order	Yes – Welfare of child is court's main consideration (Children's Act), but court's authority in needed	No – No incompetent person can withhold consent
Under 16 year olds				
Competent	Yes – But if possible also with consent of person with parental responsibility	Yes – Person with parental responsibility, High Court jurisdiction, specific issues order	Yes – Welfare of child is court's main consideration (Children's Act), but court's authority in needed	No – Competent minor who withholds consent can be overruled by court or person with parental responsibility
Incompetent	No – No incompetent person can give consent	Yes – Person with parental responsibility, High Court jurisdiction, specific issues order	Yes – Welfare of child is court's main consideration (Children's Act), but court's authority in needed	No – No incompetent person can withhold consent

Safeguarding

Children are best protected when professionals are clear about what is required of them individually and understand how they need to work together. Research has also demonstrated that every day counts for children who need additional help and co-ordinated multi-agency action can be crucial to safeguard and promote their welfare.

1. **Safeguarding is everyone's responsibility**: for services to be effective each professional and organisation should play their full part.

2. **A child-centred approach**: for services to be effective they should be based on a clear understanding of the needs and views of children.

Working Together to Safeguard Children defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment
- preventing impairment of children's mental and physical health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and
- taking action to enable all children to have the best outcomes.

The Purpose of Assessment:

Whatever formal legislation the child is assessed under, the purpose of the assessment is always:

- to gather important information about a child and family
- to analyse their needs and/or the nature and level of any risk and harm being suffered by the child
- to decide whether the child is a 'child in need' (under section 17 of the Children Act 1989) and if so, is there a need for further social work support or provision of support?
- to decide whether the child is suffering, or likely to suffer, significant harm (section 47 of the Children Act 1989) and, if there is, to initiate immediate action, and
- to provide support to address those needs to improve the child's outcomes to make them safe.

Assessment should be a dynamic process which analyses and responds to the changing nature and level of need and/or risk faced by the child. A good assessment will monitor and record the impact of any services delivered on the child and family and review the help being delivered. Whilst services may be delivered to a parent or carer, the assessment should be focused on the needs of the child and on the impact any services are having on the child.

Good assessments support professionals to understand whether a child has needs relating to their care or a disability and/or is suffering, or likely to suffer, significant harm. A good

assessment will also ensure that the specific needs of disabled children and young carers are given sufficient recognition and priority.

Principles of a good assessment:

- are child-centered. Where there is a conflict of interest, decisions should be made in the child's best interests: be rooted in child development: be age-appropriate; and be informed by evidence
- are focused on action and outcomes for children
- are holistic in approach, addressing the child's needs within their family and any risks the child faces from within the wider community
- ensure equality of opportunity
- involve children, ensuring that their voice is heard and provide appropriate support to enable this where the child has specific communication needs
- involve families
- identify risks to the safety and welfare of children
- build on strengths as well as identifying difficulties
- are integrated in approach
- are multi-agency and multi-disciplinary
- are a continuing process, not an event
- lead to action, including the provision of services
- review services provided on an ongoing basis
- are transparent and open to challenge
- When admitting a patient it is important to assess if the child or young person has any safeguarding needs. Are they on a child protection plan or child in need plan? The family should be asked but also Oasis admission system should be checked, as this holds up to date safeguarding records for the patient. This should be clearly documented in the patients admission paperwork.

- If a child is known to children's services for any reason then children's services should be notified and informed of admission. Consent from parents should be sought before phoning.

- Should you have any concerns regarding a child or family during their admission, it is important you escalate this to the nurse in charge or a trained member of staff. This should then be documented in the patient notes on a history sheet and put in a separate section of the notes with a safeguarding divider in order for it to be easily identified.

Chaperones

Please take a moment to answer the following questions:

- What is meant by the term chaperone?

  _____
  _____

- What is an 'intimate examination'?

  _____
  _____

- Why do chaperones need to be present?

  _____
  _____

- What are the rights of the patient?

  _____
  _____

- What is their role and responsibilities?

  _____
  _____

  It is important chaperones should place themselves inside the screened-off area rather than outside of the curtains/screen (as they are then not technically chaperoning).

- If you had a concern while acting as a chaperone how would you go about raising these concerns?

  _____
  _____

What is a chaperone?

A chaperone is an impartial observer present during an intimate examination of a patient. He or she will usually be a health professional who is familiar with the procedures involved in the examination. The chaperone will usually be the same sex as the patient.

Why is a chaperone needed?

All medical consultations, examinations and investigations are potentially distressing. Patients can find examinations, investigations or photography involving the breasts, genitalia or rectum particularly intrusive. These examinations are called 'intimate examinations'. Cultural factors should be considered. This is important when examinations are performed by members of the opposite sex. Also, any consultations where patients may feel vulnerable.

For most patients and procedures, respect, explanation, consent and privacy are all they need. They take precedence over the need for a chaperone. A chaperone does not remove the need for adequate explanation and courtesy. Neither can it provide full assurance that the procedure or examination is conducted appropriately.

All staff must be aware that chaperones are to protect both patients and staff.

All patients should routinely be offered a chaperone during any consultation or procedure. This does not mean that every consultation needs to be interrupted to ask if the patient wants a chaperone to be present. The offer of chaperone should be clear to the patient before any procedure.

For children and young people, their parents, relatives and carers should be made aware of the use of chaperones and why it is important that they are provided with a chaperone during any examination.

The GMC guidance states that a relative or friend of the patient is not an impartial observer. They would not usually be a suitable chaperone. There may be circumstances when a young person does not wish to have a chaperone. The reasons for this should be clear and recorded in the patients notes.

Things to include are:

- who the proposed chaperone was
- their title
- that the offer was made and declined.

GMC guidance states chaperones should:

- be sensitive and respect the patient's dignity and confidentiality
- reassure the patient if they show signs of distress or discomfort
- be familiar with the procedures involved in a routine intimate examination
- stay for the whole examination and be able to see what the doctor is doing, if practical
- be prepared to raise concerns if they are concerned about the doctor's behaviour or actions.

Patient/Family Experience

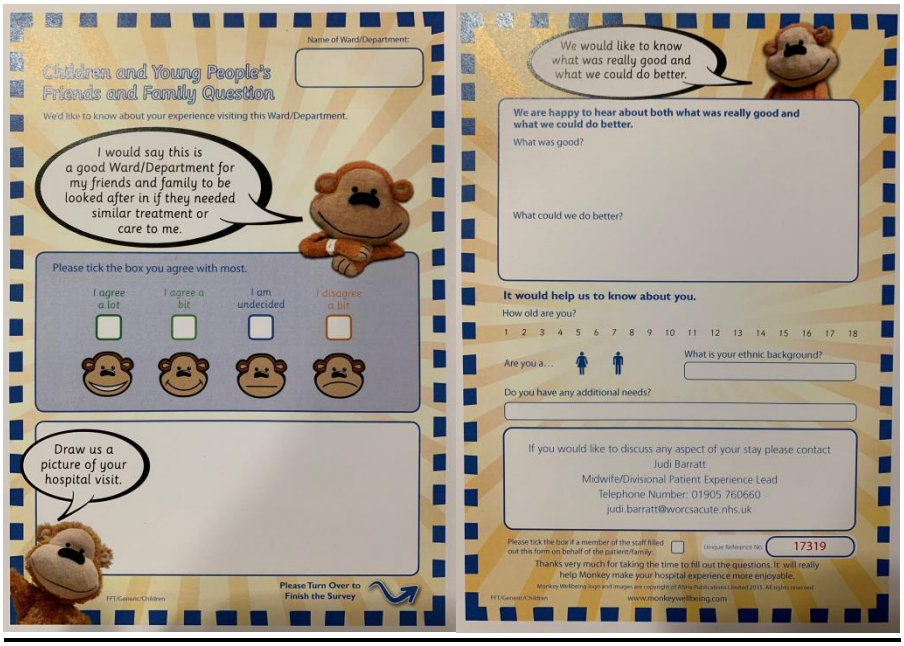
The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how. (NHS England)

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give your views after receiving NHS care or treatment.

Since the FFT was launched in 2013, millions of patients have submitted feedback. It's used by most NHS services, including community care, hospitals, mental health services, maternity services, GP and dental practices, emergency care, and patient transport.

Below is a copy of the FFT form used within Children's Services at Worcestershire Royal Hospital. Every Patient & Family that use our service should be asked to complete one of these forms. It is everyones responsibility to ensure forms have been issued to service users and results are fed back to the Trust on a monthly basis.

The feedback gathered through the FFT is being used to stimulate local improvement and empower staff to carry out the sorts of changes that make a real difference to patients and their care.



Documentation

Accurate documentation is essential to maintain continuity and inform health professionals of ongoing care and treatment. It also provides legal evidence.

THE DATA PROTECTION Act 1998 defines a health record as any electronic or paper information recorded about a person for the purpose of managing his or her health care. Guidelines for records and record keeping published by the Nursing and Midwifery Council (NMC 2002) state that: 'good record keeping is a mark of the skilled and safe practitioner'. Record keeping promotes better communication between members of the primary healthcare team, accounts for care planning and delivery of treatment, and enables changes in the patient's condition to be detected (NMC 2002).

Records should provide factual, current, comprehensive and consistent information about the assessment and care of patients (NMC 2002). Records should be written chronologically and dated and signed by the practitioner in a manner that cannot be erased, and is legible on photocopies. Records should be updated as close to the event as possible to ensure information is accurate and up to date.

Writing accurate records not only ensures quality of practice but also safeguards the nurse by providing evidence of his or her professional ability (Dion 2001). Records can be used as evidence before a court of law or regulatory body.

Documentation does not just mean the written records in patients notes it includes all areas of patient care:

- Observations – should be documented on the PEWS charts as soon as the observations have been carried out.
- Fluid Balance – fluid balance charts should be updated regularly. A MINIMUM of 4 hourly updates is required.
- Care and comfort – these should be discussed with parents on how frequently they should be carried out, these are 2-4 hourly, however, they should be documented a MINIMUM of 4 hourly.

Other documentation used on the unit includes (Appendix 5):

- Milk feed Record
- Assessment for infection
- Pressure Ulcer Risk Assessment
- Manual Handling Assessment
- STAMP 0-2y / 3-18y (nutritional status)

- Peripheral Vascular Device (PVD)
- VTE Assessment – for 16 years and above.
- Accountable Handover
- Bedside Checklist – this should be completed after a room has been cleaned in preparation for the next patient. When a new patient arrives in the bedspace this document should have the new patient sticker attached and be put in their bedside folder. ALL patients should have a labelled bedside checklist in their folder. ALL empty bedspaces should have a completed bedside checklist on the bed / in the room.
- FFT (Family & Friends Test) – all patients & their families should be asked to complete an FFT form during their admission. This is a mandatory requirement of all areas in all NHS Trusts and is audited on a monthly basis.
- Safeguarding Documentation

Reflection

Complete the table below to describe how the different development activities have helped to improve your knowledge, skills and understanding.

Description of Development Activity	How has it helped to improve your knowledge?	How has it helped to improve your skills?	How has it helped to improve your understanding?
1. A learning activity that you have undertaken recently			
2. Reflecting on a situation			
3. Feedback from others			

Reflective Practice 1

Description: What happened?	
Feelings: What were you thinking and feeling?	
Analysis: What sense can you make of the situation?	
Evaluation: What was good and bad about the experience?	
Action Plan: If it arose again, what would you do?	
Conclusion: What else could you have done? What went well?	

Clinical Area: _____

HCSW Name: _____ Signature: _____

Supervisor's Name: _____ Signature: _____

Date: _____

Reflective Practice 2

Description: What happened?	
Feelings: What were you thinking and feeling?	
Analysis: What sense can you make of the situation?	
Evaluation: What was good and bad about the experience?	
Action Plan: If it arose again, what would you do?	
Conclusion: What else could you have done? What went well?	

Clinical Area: _____

HCSW Name: _____ Signature: _____

Supervisor's Name: _____ Signature: _____

Date: _____

Person-Centred Approach

Please take a few minutes to look at the below values and complete the table.

Person-centred value	1. What does the value mean?	2. How would you put this into practice in your day to day work?	3. Why is it important to work in a way that promotes this when supporting an individual?
Individuality			
Rights			
Choice			
Privacy			
Independence			
Dignity			
Respect			
Partnership			

References:

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