NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust

Second Edition

The Great Ormond Street Hospital Manual of Children and Young People's Nursing Practices

Edited by Elizabeth Anne Bruce, Janet Williss and Faith Gibson

WILEY Blackwell

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Foreword

It is my great pleasure to be asked to write the Foreword to the second edition of the *Great Ormond Street Hospital Manual of Children and Young People's Nursing Practices*.

The Hospital for Sick Children opened in 1852 with just 10 beds. Since then, and throughout its 171-year history, Great Ormond Street Children's Hospital (GOSH) has remained a hospital dedicated to the care of children and young people and has established a reputation for being at the leading edge of care, education, and research, both nationally and internationally.

Healthcare for children across the world continues to develop as advancements in medical science, technology, and pharmacology lead to innovation and treatment breakthroughs, making the impossible possible. Children and young people with rare and complex conditions come from across the United Kingdom and the rest of the world to access our highly specialised services. Excellence in nursing is fundamental to what we can offer and plays a key role in the delivery of high standards of care and practice that we constantly strive to influence and achieve, working in collaboration with the children and young people themselves and their families. Now, more so than ever before, nurses play such a pivotal role in improvements in patient care and experience by championing developments in digital technology, making access to care and treatment easier and equitable.

Florence Nightingale once stated 'it is the real test of a nurse whether she can nurse a sick infant' (Nightingale 1859, p. 116). This manual is an inspiring body of work, contributed to by many, which showcases the profession of children's nursing, of which we are extremely proud. It supports the delivery of evidence-based practice across a wide variety of topics, updated original guidance, as well as introducing new aspects of practice, and is essential reading for *all* nurses and other healthcare professionals involved in caring for children and young people across acute, community, and primary care settings.

Reference

Nightingale F 1859 (1952) *Notes on Nursing: What it Is, and What It Is Not.* London, UK, Harrison.

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Introduction

We made a decision to write this introduction last. We wanted to set the scene for what was to follow and therefore needed to know what followed before we put finger to keyboard. Our intention here is to highlight a number of principles that should underpin all clinical care given in community and hospital settings, all of which are the cornerstone of the content of chapters in this textbook. The guidelines contained herein are not intended to replace individual assessment and personalised treatment and care of the child or young person (CYP) and their carers/family. Instead, our intention in presenting this information is to bring to nurses and other healthcare professionals delivering healthcare to CYPs the latest evidence that underpins clinical care; the *how to* and *why* of many of the clinical procedures undertaken. The first principle that guides us in our work regards individualised care.

Individualised care

The mission for Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) is to put the 'child first and always' (GOSH 2020). This continues to underpin the work of every person employed at the hospital. To deliver on this mission, each CYP needs to be seen as a 'whole' being in the context of their family, carers, school, friends, and local community. This perspective should involve an understanding that, as CYPs grow up and develop, their needs will change. Knowledge of child development, family structures, communication patterns and the wider social networks CYPs live within is important for us to understand how we approach care delivery. Using a family systems approach to nursing is not new, but we, and the practitioners who have contributed to this textbook, would recommend its use to ensure that the focus is on the care of the whole family (Hemphill and Dearmun 2010). We would also suggest having in place an ideal care delivery model (Pordes et al. 2019) that includes the creation of proactive plans based on the goals of the family and CYP, where multidisciplinary, shared decision-making is facilitated and recorded, and a professional such as a key worker familiar with the CYP and family is involved to address comprehensive needs (Ogourtsova et al. 2018).

CYPs also have rights as human beings and need special care and attention (United Nations International Children's Emergency Fund [UNICEF] 1989). This Convention was the first legally binding international instrument to incorporate the full range of human rights for CYPs; civil, cultural, economic, political, and social rights. Each CYP has the right:

- For survival – to be given food and water and opportunities for healthy growth.
- To develop to the fullest – to achieve and enjoy through education.
- To protection from harmful influences, abuse, and exploitation – to stay safe.
- To participate fully in family, cultural, and social life – to make a positive contribution and achieve economic well-being.

Now, 30 years since it was ratified (https://www.unicef.org/child-rights-convention), readers are encouraged to take a few minutes to watch some of the more recent videos that show what CYPs are doing to use their rights; see, for example, https://www.youtube.com/watch?v=y4udqAY2Bqc and https://www.youtube.com/watch?v=DtzlxpDRiMk.

Our role in healthcare is to ensure that CYPs reach their fullest potential, and thus limit whenever we can the short- and long-term effects that result from health changes. Most CYPs will experience the healthcare system in some way during their life; for example, vaccinations, school health checks, dental checks, sexual health, maternity services, or, if they become unwell, a visit to their local doctor or a hospital referral. It is important that within each of these different contexts the CYP is seen as an individual within the family. Throughout this textbook there are many examples of approaches to ensure this aim will be achieved in your approaches to care.

Family-centred care

Our second principle is the need to fully understand the methods of a family-centred approach to care. This takes the notion of individualised care further, with family-centred care (FCC) viewed as a central tenet of CYPs' nursing (Coleman 2002). An FCC model is widely used in the care of CYPs in hospital. This encompasses the holistic psychosocial-economic need to always see CYPs within a family concept. Hutchfield (1999) analysed the concepts of FCC and found that partnership with parents, parent participation, and care by parent were the most common systems applied in practice. These systems were meant to help clarify for parents their caring roles, and make explicit how professionals and parents would work together. 'The social construct of family-centred care has been refined again and again and within this construct parents have moved from a passive presence to being allowed to take on a more active role in their child's care in hospital' (Coleman 2002, p. 9).

More recently, O'Connor et al. (2019) undertook a concept analysis of FCC and concluded that the concept continues to evolve. Attributes included parental participation in care, the development of respectful and trusting partnerships and information sharing, with all family members as care recipients. O'Connor et al. (2019) reaffirm that the effectiveness of family-centred care has not been measured sufficiently and argue that although nurses can support the principles of it, very few can really define it and say what works best in different situations; empirical evidence continues to be absent. Despite this lack of evidence and lack of a single definition of FCC, we would strongly support the application of an FCC approach to care, in which nurses work within family structures to care for CYPs effectively and support family members in their roles, whether they be nursing or family roles; where parents are able to negotiate with health staff to determine what this participation will involve and negotiate new roles for themselves in sharing the care of their sick CYP. Parents should be involved in the

Table I.1 Relevant legislation and policies.

The Human Rights Act 1998	https://www.equalityhumanrights.com/en/human-rights/human-rights-act
The Children Act 2004 – The legal framework for England and Wales	www.legislation.gov.uk/ukpga/2004/31/contents
Protection of Vulnerable Groups (Scotland) Act 2007	www.legislation.gov.uk/asp/2007/14/contents
Protection of Children (Scotland) Act 2003	www.legislation.gov.uk/asp/2003/5/contents
Children (Northern Ireland) Order 1995	www.legislation.gov.uk/nisi/1995/755/contents/made
Safeguarding Vulnerable Groups (Northern Ireland) Order 2007	www.legislation.gov.uk/nisi/2007/1351/contents
Children and Young Persons Act 2008	www.legislation.gov.uk/ukpga/2008/23/pdfs/ukpga_20080023_en.pdf
The Children's Plan (Department for Children, Schools and Families 2007)	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/325111/2007-childrens-plan.pdf
Children and Families Act 2014	www.legislation.gov.uk/ukpga/2014/6/contents/enacted
Children and Social Work Act 2017	www.legislation.gov.uk/ukpga/2017/16/contents/enacted
Healthy Children: Transforming Child Health Information (NHS England 2016)	https://www.england.nhs.uk/wp-content/uploads/2016/11/healthy-children-transforming-child-health-info.pdf
Working Together to Safeguard Children (HM Government 2018)	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf
Protecting Children from Trafficking and Modern Slavery (National Society for the Prevention of Cruelty to Children (NSPCC) 2021)	https://learning.nspcc.org.uk/child-abuse-and-neglect/child-trafficking-and-modern-slavery
The Children Act 1989 Guidance and Regulations (Department for Education (DfE 2021)	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/441643/Children_Act_Guidance_2015.pdf
Female Genital Mutilation Act 2003	www.legislation.gov.uk/ukpga/2003/31/contents

decision-making process. We recommend the family-centred practice continuum described by Coleman et al. (2003) to practitioners; this will help you help parents/carers decide on the degree in which they may be active participants in their child's care, including planning, delivery, and management. As suggested by Al-Motlaq et al. (2019), guidance documented in this textbook reflects the philosophy of FCC and its major components.

Making reasonable adjustments to care

Under the Equality Act (2010), health services must consider the needs of people with disabilities in the way they organise their buildings, policies, and services. These are called 'reasonable adjustments' and reflect the fact that some people with disabilities may have particular needs that standard services do not adequately meet. This could relate to, for instance, people with learning and/or physical disabilities. Making reasonable adjustments for CYPs in our care is our third principle. In the context of this textbook, this relates to the need for tailored information and advice to be offered in formats and languages that people can understand; for extra time to be offered to people who have particular communication needs or difficulty understanding what is being said; and ensuring that CYPs and their families are fully prepared for a clinical procedure by listening to what their individual needs might be.

We know that developmentally appropriate and individually tailored preparatory information has a positive effect on CYP's experiences of clinical procedures (Bray et al. 2019a). We also know that there is an added complexity when working with CYPs who have a learning disability, whereby 'individually tailoring' may well require additional preparatory time. Added to this, we are well aware of the range of practices that fall within the term *physical holding*, used to facilitate a clinical procedure being completed (Bray et al. 2018). There is a need for more evidence on how clinical practice guidelines inform professional practice and CYP's views of how their opinions and choices should be sought and attended to in the process of a procedure being completed. But in the meantime, we recommend an initial assessment, working closely with parents/carers in order to understand fully a CYP's needs; this might well reveal social communication difficulties associated with autism, or the presence of challenging behaviour (Absoud et al. 2019). Bray et al. (2019b) have highlighted that during a clinical procedure there are many factors that can 'tip' the balance toward a CYP's expressed wishes being undermined and their feelings of being held against their will. An initial assessment can anticipate the presence of these factors. The need to balance different agendas, rights, and priorities within the momentum that can build during a clinical procedure requires professionals to feel equipped to enact a 'clinical pause': an opportunity to establish a balanced approach that acknowledges the CYP's agency within healthcare procedures. Initial assessment and clinical pause are two approaches that inform and enable a nurse's ability to make a reasonable adjustment.

Legislation and policy relevant to care

Our fourth principle stresses the need for clinical professionals working with CYPs to be conversant with legislation and general guidance for the welfare of CYPs. There is a complex legal framework relevant to the provision of care and treatment to CYPs, and this may vary across the four countries in the UK as well as across international boundaries. Added to this, the development of human rights law has contributed to the increasing recognition of the need to give greater weight to the views of CYPs as they develop their understanding and ability to make their own decisions. However, there are occasions when the adults with the responsibility for the care and treatment of young people have to make decisions and take actions on their behalf to ensure their well-being. Therefore, knowledge regarding the various legal frameworks will always be timely, and it falls to the professional to keep this up to date. Access

to computers at unit/ward level makes this task much easier than it ever was, with access to professional databases and PubMed. In addition, organisations such as the Care Quality Commission (CQC 2022) produce lists of legislation that may be relevant to health and social care. In Table I.1 we draw the reader's attention to some of the legislation and policies relevant in the UK today and include websites where up-to-date information can be found.

Code of conduct that underpins care

Our fifth principle is the need to be conversant with the Nursing and Midwifery Council (NMC) code of conduct. Nurses and other healthcare staff must act as advocates for the CYP when necessary (NMC 2018). The people in your care must be able to trust you with their health and well-being. The Code is shaped around four statements, which state that good nurses will:

1. Prioritise people
2. Practise effectively
3. Preserve safety
4. Promote professionalism and trust

As a professional, you are personally accountable for actions and omissions in your practice and you must always be able to justify your decisions. The Code should be considered alongside the NMC's rules, standards, guidance, and advice, available from www.nmc-uk.org. The NMC web site is kept up to date and should be able to guide you in aspects of the code and guidance; your role as a practitioner is to keep up to date with this.

Delivering culturally sensitive care

As nurses, we need to be confident in our role to deliver culturally sensitive care to families; this is our sixth principle. Family ethnicity includes race, culture, religion, and nationality, which impact on a family or person's identity and how they are seen by others. Health is shaped by many different factors such as lifestyle, material wealth, educational attainment, job security, housing conditions, psychosocial stress, discrimination, and the health services. We know that health inequalities exist within different ethnic minority groups and represent the cumulative effect of these factors over the course of life; they can be passed on from one generation to the next through maternal influences on baby and child development. Initiatives aimed at reducing poverty, social exclusion, and difficulty in accessing health services have the potential to tackle the root causes of health inequalities. Some community initiatives aiming to reduce health inequalities and social exclusion by targeting deprived areas are Health Action Zones (www.haznet.org.uk), Neighbourhood Renewal (www.neighbourhood.statistics.org.uk), the New Deal for Communities (www.communities.gov.uk), Sure Start (http://www.early-years.org/surestart/), and more. Recently, the Spearhead Area initiatives (National Audit Office 2010; Barr et al. 2017). An understanding of such schemes can help nurses to be aware of support networks available to the families in our care.

The concept of 'culture' is not homogeneous and one should avoid using generalisations in explaining families' beliefs or behaviours. One should differentiate between the rules of a culture, which governs how one *should* think and behave, and how people actually behave in real life. Generalisations can be dangerous as they often lead to misunderstandings, prejudices, and discrimination. There may be conflict within a family that holds certain beliefs when their CYP has been influenced by different outside social forces. Cultural background has an important influence on many aspects of a CYP's life, including their beliefs, behaviours, perceptions, emotions, language, religion, rituals, family structure, diet, dress, body image, and concepts of space and time. It also plays a part in attitudes to illness, pain, and other misfortunes (Helman 2007). It is important to interpret behaviour or beliefs within its particular context, which is made up of historical, economic, social, political, and geographical elements. This may, for example, have an influence on CYPs or parents who are nonadherent with their medical/nursing care and are seen as 'difficult.'

In most cultures, boys and girls are socialised in different ways and this varies throughout the world. For example, men may play a more predominate part in public life in some cultures, but the 'grandmother' of the family (who is seen as being wiser) may be the decision maker on the way the CYP is brought up. Artificial changes of the body, such as body piercing, tattooing, or artificial fattening are often deemed as notions of beauty in some cultures. Extreme cases such as female circumcision or female genital mutilation (FGM) and severe obesity will affect health and well-being and should be dealt with accordingly. For more information on FGM, which is illegal in the UK see Chapter 31: Safeguarding Children and Young People. Different religious beliefs may include ritual immersions, fasts, food taboos, circumcision, communal feasts, and mass pilgrimages. Some of these may be associated with health concerns such as malnutrition with food taboos, where cultural beliefs and practices misalign with best practices in healthcare (Aghajari et al. 2019). The challenge relates to providing culturally competent care and effectively communicating with families from diverse cultural and ethnic backgrounds who have different health beliefs, practices, values, and languages (Tavallali et al. 2017).

Healthcare professionals should not assume that everyone knows how his or her body works. Many people see it as a 'plumbing system' or machine, and believe that body parts and cavities are connected by pipes (Helman 2007). It is important to ensure that families and CYPs understand their particular health problem and that this is communicated by both oral and written information in their native language, using props that might best help us explain what is happening. An interpreting service should be available to families and CYPs whose first language is not English. Healthcare workers must be sensitive to the world that CYPs and their families live in and ensure that cultural differences or even different views on health are taken into consideration, recorded where necessary, and communicated appropriately to the clinical team.

Consent and involving CYPs in decisions about their care

Throughout this text-book there is an emphasis on ensuring CYPs are communicated with directly and wherever possible are involved in all decisions about their healthcare. We know from many different sources that CYPs want to be involved in the discussions and decisions that affect their health (Royal College of Paediatrics and Child Health, [RCPCH] (2017). In addition, the UN Convention on the Rights of the Child outlines the legal requirements for engaging and involving CYPs in the strategic influence of their healthcare. Article 12 recommends that:

> Children have the right to give their opinions freely on issues that affect them. Adults should listen and take children seriously (UNICEF 1989).

Involving CYPs in decisions about their healthcare can help their understanding of the disease and treatment, reduce their fears, and help them feel more prepared and to cope better. Although there is minimal evidence about what approaches work best for involving CYPs in decision making, we are supportive of communication practices that assist CYPs in this decision-making process (Boland et al. 2019).

In all the relevant sections of this textbook the authors have provided supporting literature on the issue of consent relevant to clinical procedures. We thought this an important seventh principle, and

want to highlight in particular the guidance that should be fully understood by all nurses delivering healthcare to CYPs, see for example the recommendations from the Care Quality Commission (CQC 2019). There are a number of documents we want to recommend in this section and list them here. All are based on English law: Healthcare practitioners must follow professional and local guidelines and ensure they are kept up to date, as further legal developments may occur and the law may differ in other countries.

General Medical Council (2018a): *Protecting Children and Young People*	https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people
General Medical Council (2018b): *0–18Years: Guidance for All Doctors*	https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years
Wilacy and Tidy (2021): *Consent to Treatment in Children*	https://patient.info/doctor/consent-to-treatment-in-children-mental-capacity-and-mental-health-legislation
British Medical Association (2021): *Children and Young People Ethics Toolkit*	https://www.bma.org.uk/advice-and-support/ethics/children-and-young-people/children-and-young-people-ethics-toolkit
RCPCH (2012): *Pre-procedure Pregnancy Checking*	www.rcpch.ac.uk/sites/default/files/Guidance.pdf

All the above guidance should be read in conjunction with the Human Tissue Act (2004) and the Mental Capacity Act (2005). They should be read in conjunction with the issues highlighted in each section of this textbook. We would also refer you to sources on YouTube; in particular, look for accounts of CYPs talking about what this process is like – see, for example, https://www.youtube.com/watch?v=837PKaIAk24.

Restrictive physical interventions and clinical holding

NHS Trusts are committed to providing the best-quality care from a compassionate, caring, and competent workforce. As we have discussed, this is best achieved by working in partnership with CYPs and their families to obtain their consent for procedures. However, there are times when the CYP may need to be held still or 'restrained', with or without their explicit consent or that of their parents/carers, so that care can be delivered safely and effectively. This can raise many complex legal, ethical, and practical issues. Clinical holding refers to immobilisation, which may be by splinting or by using limited force. It may be a method of helping CYPs, with their or their parent/carer's permission, to manage a painful procedure quickly and effectively. 'Clinical holding has been distinguished from restrictive physical intervention by the degree of force used, the intention of the hold, and the agreement of the child' (Royal College of Nursing (RCN) 2019).

As just discussed, valid consent should be sought for all forms of healthcare and is particularly important if the CYP must be held still or 'restrained'. This section provides guidance to all staff regarding the use of restrictive physical interventions (formerly known as restraint) and clinical holding of CYPs. It is designed to be read in conjunction with other local and national policies and guidelines. Recent government guidelines focus primarily on restraint in social, educational and community settings (HM Government 2019) and there is currently no precise government guidance on the use of restrictive physical interventions, restraint or clinical holding of CYPs in hospital. The following documents have been incorporated into the principles that underpin this policy and may provide additional information to guide good practice:

- The Children Act 1989
- Human Rights Act 1998
- The United Nations Convention on the Rights of the Child (1989)
- Positive and Proactive Care: Reducing the Need for Restrictive Interventions (DH 2014)
- The Mental Health Act (1983)
- Restrictive Physical Interventions and Therapeutic Clinical Holding of Children and Young People: Guidance for Nursing Staff (RCN 2019)

Individual practitioners remain accountable for protecting the rights and the best interests of their patients while maintaining the standards of practice set out by their own professional body (Nursing and Midwifery Council 2015, updated 2018).

Principles of good practice

- Restrictive physical intervention or clinical holding should be used as the last resort and not the first line of intervention (RCN 2019).
- There should be openness about who decides what is in the CYP's best interest. Where possible, these decisions should be made with the full agreement and involvement of the CYP and their parent or carer (RCN 2019).
- Staff should not be deterred from normal social contact; however, they should try to ensure that a CYP does not misinterpret any physical contact. Developmental age and gender should be considerations in deciding the level of appropriate physical contact.
- Staff should ascertain the significance of physical contact through discussion with the CYP, family, professionals, and previous carers. If the CYP is not comfortable with physical contact, this should be recorded and considered throughout their stay; however, this would not necessarily mean physical contact would be withheld if considered necessary. Cultural factors will be significant in determining what is considered to be acceptable in terms of physical contact.
- Clinical holding and restrictive physical intervention should be employed to achieve outcomes that reflect the best interests of the CYP (i.e. to deliver safe and effective care) and/or others affected by their behaviour (i.e. to prevent the CYP from causing injury to him- or herself or others).
- Serious consideration must be given to the appropriateness of applying to the High Court if there are indications that physical force or unusual restraint needs to be used in order to give treatment, even if the parents/carers consent.
- Clinical holding or restrictive physical intervention should not arouse sexual feelings or expectations (RCN 2019) and should cease if the CYP gives any indication of this.
- Where a member of staff feels it would be inappropriate to respond to a CYP seeking physical contact, the reasons for denying such contact should be explained.
- There should be sufficient staff available who are trained and confident in safe and appropriate techniques and alternatives to restrictive physical intervention and clinical holding of CYPs.
- Staff working within mental health units and services should receive specialist and regular updates to maintain skills as appropriate. These staff can act as a resource within the Trust, should specialist techniques be required.
- There is guidance for parents to read, please see https://www.gosh.nhs.uk/conditions-and-treatments/procedures-and-treatments/therapeutic-holding/.

Prevention

- Staff should communicate with CYPs in a way that maximises and promotes their understanding of their illness and treatment. Time

spent talking and explaining procedures to them and their family may avoid the need for clinical holding or restrictive physical intervention altogether.
- Clinical holding and restrictive physical intervention should be used only if other preventive strategies such as dialogue, diversion, and distraction techniques have been unsuccessful. Clinical staff should be trained and competent in these preventive strategies and in clinical holding and restrictive physical intervention of CYPs for clinical procedures.
- Clinical staff working in 'high-risk' specialist areas (e.g. mental health units) may need additional training in de-escalation techniques.

Specific advice regarding infants and young children

- When young children are being cared for in hospital, it will not usually seem practicable to seek consent from their parents/carers for every routine intervention such as blood or urine tests or X-rays that may require a degree of restraint. However, it should be remembered that, by law, such consent is required. Therefore, discussion of the procedures with the child and their parent/carer should take place in advance to obtain their consent.
- If the child or their parents/carers specify that they wish to be asked before certain procedures are initiated, this must happen, unless the delay involved in contacting them would put the child's health at risk.

Clinical holding for planned procedures

- For planned procedures (e.g., to pass a nasogastric tube or to take blood), consent should be sought in accordance with local policy. If staff will have to hold the CYP to carry out the procedure, the person giving consent should be made aware of this and their consent sought. Consent may be verbal and sought in advance of the procedure (i.e. on admission).
- The involvement of parents/carers may reduce the level of clinical holding needed. Consideration should be given to full parental involvement in the examination and/or treatment, as this may significantly reduce the CYP's anxiety. Staff should recognise that the procedure may be as stressful and distressing for the parent/carer as for the CYP and should ensure that appropriate support is available.
- Gentle protective containment of the CYP with bolsters, pads, and light straps to gain and maintain the correct positioning for diagnostic imaging, or to protect the restless CYP from self-injury, is acceptable. Parents/carers may gently restrain their own child (e.g. to limit movement during cannulation).
- Staff should, if at all possible, have an established relationship with the CYP and should clearly explain what they are doing and why.

Clinical holding in emergency situations

- If consent has not been sought and it is necessary to hold a CYP to perform an emergency or urgent intervention, there should be careful consideration of whether the procedure is really necessary, and whether delaying the procedure to contact the parents/carers would put the CYP's health at risk. Wherever possible, the procedure should be delayed until consent has been obtained (RCN 2019).
- If immediate initiation of the procedure is deemed to be in the CYP's best interests, every effort should be made to gain their cooperation.

Restrictive physical intervention (restraint)

- Restrictive physical intervention is permissible in circumstances where staff are attempting to (i) avert an immediate danger or injury to the CYP or another individual, or (ii) avoid immediate damage to property, where any other course of action would be likely to fail.
- Staff should take steps in advance to avoid the need for restrictive physical intervention, such as through dialogue and diversion, and the CYP should be warned verbally that physical restraint will be used unless they desist.
- Restrictive physical intervention is distinguished from clinical holding by the degree of force required. At all times, the degree of force used must be reasonable and proportionate to both the behaviour of the individual to be controlled and the nature of the harm they may cause. These judgements must be made at the time, taking account of all the circumstances, including any known history of other events requiring restraint.
- The minimum necessary force should be used.
- The techniques deployed should be those for which staff are trained and familiar with, and are able to use safely. The team leader should be clearly identified and should ensure that all staff are aware of their individual roles during the period of restraint.
- Restrictive physical intervention should avert danger by preventing or deflecting a CYP's action or by removing a physical object. Averting harm by causing or threatening hurt, pain, or distress is unacceptable (except in wholly exceptional circumstances such as self-defence).
- Restrictive physical intervention should not be used purely to force adherence with staff instruction when there is no immediate risk to people or property.
- Every effort should be made to secure the presence of other staff before applying restraint. The number of staff needed will vary with the situation. If possible, a member of staff of the same sex as the CYP should be present.
- Restrictive physical intervention should be disengaged by degrees as the CYP calms down in response to physical contact. As soon as it is safe, restraint should be gradually relaxed to allow the CYP to regain self-control.
- Debriefing of the CYP and everyone involved should take place as soon after the incident as possible (RCN 2019).
- The senior nurse and the CYP's parents/carers must be made aware of all incidents requiring a restrictive physical intervention and the CYP's doctor should be informed of incidents lasting more than 30 minutes.
- All incidents should be fully documented and the Trust's local procedures for reporting incidents should be followed.

Documentation

- All staff involved must keep detailed and accurate records of each occasion where a CYP is held or 'restrained'.
- An incident report form must be completed and reported in accordance with local policies whenever restrictive physical intervention is used.

Communication and handover to improve quality of care

Communication, and the ability to communicate complex information to CYPs and family members, features in all our stated principles so far. We encourage practitioners to learn effective communication strategies to ensure CYPs and their parents/carers have the information they need in the appropriate format (Matthews 2010). In principle number 9, we want to turn to the importance of communication between professionals. Nurses have always had a 'ritual' for handing over patient information from one another when changing shifts but the quality and accuracy of the information has often been called into question. One of the greatest sources of frustration for CYPs and their families is the lack of integration and communication between different services within an organisation or between organisations.

Handover is the system by which the responsibility for immediate and ongoing care is transferred between healthcare professionals. CYPs and their families expect and should have a designated consultant and nurse to coordinate the multidisciplinary team. However, at times (e.g. at night, during weekends, or during an emergency admission), the responsibility for care must pass from one team or consultant to another (Royal College of Physicians 2011). Poor handover between doctors, nurses, and

multidisciplinary teams is a common cause of error in hospitals and a major preventable cause of patient harm. It can lead to inefficiencies, repetitions, delayed decisions, repeated investigations, incorrect diagnoses, incorrect treatment, and poor communication with the patient. Some hospitals do not even have a handover protocol in place (Royal College of Physicians 2011). The handover should be written or recorded and each professional involved in the CYP's care should have access to it at all times. There is no reason why CYPs or their parents should not listen to their own handover unless this is felt to be medically inappropriate.

Communication during verbal handover should also be standardised to improve accuracy and safety. A communication tool developed by the US Navy and adapted for healthcare (Hohenhaus et al. 2006) has been further adapted by clinical teams at GOSH. A 'D' (decisions) has been added to the acronym SBAR (situation, background, assessment, recommendation) to 'round off' each conversation and improve clarity (SBARD). Over one third of wards at GOSH have improved the efficiency and effectiveness of their handover using the SBARD communication tool. On average, wards using SBARD have reduced the length of time spent in handover by 30–50% – that is 10–20 minutes twice each day. Nurses who now use SBARD also report that their handovers feel safer and more effective, as everyone involved focuses on patient care needs for the next shift and beyond, rather than reviewing what has happened in the past. This method is also being used to communicate the needs of the deteriorating CYP. Although yet to be formally evaluated within the context of CYPs' healthcare, we are recommending its use to readers of this textbook, and refer you to studies that have looked at the quality of handover (Ruhomauly et al. 2019).

Of further assistance in our approach to communication between professionals is the increasing use of electronic patient records and the introduction of a paperless NHS (Parliamentary Office of Science and Technology 2016). The increased use of electronic patient records in the NHS means that up-to-date information about patients is readily available to a range of health professionals who are treating and caring for those patients (Griffith 2019); assisting in more effective communication between professionals.

The nine principles outlined here briefly are, we suggest, important to all the chapters that follow. Delivering safe care, managing procedures effectively, and working with all family members sensitively are important to ensure that we as nurses can be confident of delivering high quality care. Nurses have a central role in helping CYPs and their family members to manage the demands of clinical procedures as part of a unique illness experience. Even when the procedure has been undertaken many times before and we are caring for 'expert patients,' our attention to individualised patient assessment will enable us to work effectively alongside family members. The latest research and evidence for procedures must underpin all our approaches to care. Nurses have a responsibility to provide the highest standard of care; to do that they must keep up to date. The chapters that follow facilitate this level of knowledge and practice, and point readers to places where they can continue to stay current. We conclude by reminding nurses of their responsibilities, and would encourage use of journals such as *Evidence-Based Nursing* and *Worldviews on Evidence-Based Nursing*, alongside speciality journals and National Institute for Health and Care Excellence (NICE) Evidence search tools for authoritative evidence for healthcare.

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Chapter 1

Assessment

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Chapter contents

Procedure guidelines

The Great Ormond Street Hospital Manual of Children and Young People's Nursing Practices, Second Edition. Edited by Elizabeth Anne Bruce, Janet Williss, and Faith Gibson.

2 Introduction

Assessment forms the first part of any nursing activity and is the first step in delivering nursing care. Without a comprehensive assessment of the child or young person (CYP) and family's needs, care cannot be planned, delivered, or evaluated effectively (Broom 2007). For most CYPs and their families, the nursing assessment is often the first contact that they have with the nursing team and it is important that this is seen as a positive, helpful, and informative process (Moorey 2010a).

Each CYP and member of their family should be approached as an individual. Much about the CYP's illness or problem can be discovered through observing them at play, or interacting with their family, without the nurse needing to touch or examine them.

To aid ease of use, this chapter is organised into six distinct sections.

Section 1: General Principles: This section outlines the general principles that should run throughout the assessment process, and which should support the nurse's assessment of the CYP.

Section 2: Present Illness: Issues surrounding the CYP's present illness are then explored and this includes examining the current issues that have brought the CYP into the healthcare setting.

Section 3: Past History: For many CYPs, their current problems may be related to previous illnesses and/or injuries, so this forms an important part of the assessment process.

Section 4: Family History: Likewise, many conditions may be hereditary or have a tendency to run in families, so the health history of other family members may provide important information on actual or potential health problems for the CYP.

Section 5: Vital Signs and Baseline Measurements: The measuring of vital signs is a core essential skill for all healthcare practitioners working with infants and CYPs (RCN 2017). It provides valuable information about the CYP's state of health and can identify signs of illness, disease, or deterioration, allowing early intervention and treatment. Standards for assessing, measuring, and monitoring vital signs in infants and CYPs have been described (RCN 2017). Vital signs are also a core component of a paediatric track and trigger or early warning system. These systems can assist staff in recognising CYPs 'at risk' of deterioration (Chapman et al. 2016) and form part of the safe system framework for those at risk of deterioration recommended by the Royal College of Paediatrics and Child Health (RCPCH 2018). Other routine measurements, such as height and weight, provide essential information about the CYP's growth and development, which is especially important in cases of chronic illness.

Section 6: Review of Body Systems: The subsequent physical examination is separated into nine 'systems' based on the approach used throughout the 'admission assessment' documentation currently in use at Great Ormond Street Hospital. The information gained thus far should be utilised to guide the nurse on the structure and depth of the physical examination of each system. The process is not designed to be fragmented, but to encourage the nurse to structure the examination around the CYP and family's individual needs, while providing a comprehensive healthcare assessment. Not every system will need to be examined to the same depth, but if actual or potential problems are identified within a certain system, special attention should be paid to examining that area in detail. The 'systems review' section is designed to be read in conjunction with other relevant chapters of this book.

Finally, assessment is an ongoing, dynamic process. Although this chapter provides a structured approach to performing a full nursing assessment, it is not designed to be prescriptive and the nurse should remain responsive to the CYP and family's needs at all times. Assessment of the CYP is also addressed in many other chapters in this book, including but not limited to Chapter 9: Early Recognition and Management of the Seriously Ill Child; Chapter 21: Neurological Care (neurological observations); Chapter 23: Orthopaedic Care (neurovascular observations); and Chapter 24: Pain Management (pain assessment).

Section 1: General principles

Procedure guideline 1.1 General principles of assessment

Statement	Rationale
1 Before undertaking the assessment, the nurse should consider the CYP's age, gender, culture, and religious beliefs, as well as their physical and developmental needs.	1 These factors should influence how the nurse approaches the assessment process.
2 Throughout the assessment process the nurse should refer any serious concerns about any aspect of the CYP's well-being to a senior nursing or medical colleague.	2 To ensure that if help is immediately required, it is sought quickly and from the appropriate source.
3 The nurse should be familiar with the parent-held child health record (commonly known as the 'red book'), previous healthcare records, and referral letter if appropriate.	3 To guide the assessment process, avoid unnecessary repetition, and highlight priorities for assessment.