



Royal College  
of Nursing



# Health care service standards in caring for neonates, children and young people

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## Introduction

The Royal College of Nursing (RCN) actively campaigns for national standards to meet the needs of children and young people. It promotes the commissioning of services which are specifically orientated to children and young people, and it advocates the provision of appropriate environments and nursing services for children and young people in all health care settings (RCN, 2004a). The RCN also endorses the view that, rather than professional roles or boundaries, it should be the child or young person's needs which are paramount in the way services are developed (Kennedy, 2001; RCN, 2003, 2003b, 2007).

All RCN statements about care of these client groups are based upon these underlying principles, and they also reflect the importance of all agencies working collaboratively.

Over the years, many publications and inquiry reports such as Kennedy (2001) and the Allitt Inquiry (Clothier, 1994) have highlighted the special needs and rights of children and young people. This RCN guidance document, *Health care service standards in caring for neonates, children and young people*, relates to the themes emerging from recent publications from government departments, the Department of Health (1989, 1991, 1996, 2004c), Welsh Office (1991), Welsh Assembly Government (2002, 2004) and Scottish Government (Scottish Executive, 2006a); from national reports and inquiries into children's and young people's services including Kennedy (2001) and Royal College of Paediatrics and Child Health (2002); and from the RCN's own guidance documents (RCN, 2001, 2003b, 2004a).

The standards outlined in this new document apply across the four countries of the United Kingdom. The organisation of care may vary to suit the needs of each country's health strategy, but the RCN promotes these standards as essential to ensure the highest standards\* of care and wellbeing for all children, young people and their families in health care services wherever they are in the four countries of the UK.

\* Definition, standard meaning: a level of quality, an example against which others are judged or measured. Moral principle. Distinctive. Collins English Dictionary (1991)

## 2

## Health service standards for children and young people

### The changing scene in children and young people's health

The past decade has seen many changes in health issues for children and young people across the UK. With advances in clinical innovation and intervention, societal changes that affect the way we live our lives, and international influences that are changing the needs of the resident population as well as our migrant communities, these changes are rapid, irreversible and far reaching (DH, 2004a, 2004c).

These changes – and many more besides – are responsible for the way that services are now being planned, managed and delivered. This diversity of need and service provision will touch the lives of all children and young people whichever UK country they live in, community they belong to or family they are a part of. Multi-agency and multi-professional working is as essential now as it has ever been, and is pivotal not only in ensuring that the needs of this client group are met, but also in raising expectations of the high standards required to enhance the health and well being of children and young people. This will ensure that these clients are never far from the top of each government's health agenda (DH, 2003a, 2004a; Scottish Executive, 2007; WAG, 2004, 2005, 2005a, 2005b).

Some changes have been central in developing the partnership working we see today in many external agencies and voluntary sector organisations (DH, 2003a; WAG, 2005b). These include the fact that children and young people with life-limiting and life-threatening illnesses now require much longer-term care provision which often continues intermittently throughout their lives (DH, 2007a). Another factor, shown in growing evidence, is that mental ill health in childhood and adolescence is becoming very common and is increasingly more recognised (RCN, 2004b). There is also a move from in-patient admissions and lengthy hospital stays to managing children and young people's care through ambulatory care and community-based teams, who treat patients at home, school and voluntary activity settings (RCN, 2003c).

### The RCN health care service standards

A standard is a level of quality against which other aspects can be measured.

The themes which are reflected in these RCN standards for the care of children and young people fall under the following headings:

- ◆ working with children/young people and their families – a multi-agency approach
- ◆ preventing hospital admission – day care and community-based services
- ◆ the environment and facilities for children, young people and their families
- ◆ keeping the environment safe for children, young people and their families
- ◆ employment, staffing levels and skill mix of children's nurses
- ◆ educating the children's nursing workforce.

## 3

## Monitoring and auditing the RCN standards

It is important to monitor whether the required standard is being achieved on a consistent basis – if there is no measurement, the whole process of setting standards becomes redundant. If the level of quality measured falls below the agreed/required level, it is a cause for concern and corrective action is needed.

Organisations can monitor the achievement and maintenance of standards through a process of audit, based on a pre-determined set of measurement indicators. The organisation should determine the frequency of these regular audits. Where an audit shows that results are below the standard, then the organisation should develop an action plan, highlighting areas and methods to bring about a sustained improvement. For accountability, this action plan should appoint either individuals or designated roles as responsible for undertaking or supervising the action points.

This kind of audit of achievement against standards will bring about improvements in clinical practice and lead to sustained improved quality of care for patients and their families.

## Service standards

### SECTION 1: Working with children/young people and their families – a multi-agency approach

#### 1.1 The importance of the child, family and professionals working together

##### Standard 1

Services for children, young people and their families should be provided by a range of health and social care professionals and agencies working collaboratively, to ensure the highest standard of care for children and young people at all times.

##### Supporting evidence/rationale

- ◆ A key theme of *The NHS Plan* (DH, 2000) is partnership between patients and professionals.
- ◆ The *National Service Framework for Children, Young People and Maternity Services* (DH, 2004c) describes children, young people and parents as partners in their care. This is also evident within the *NHS Framework for Children, Young People and Maternity Services in Wales* (WAG, 2004).
- ◆ Governments across the United Kingdom recognise the importance of greater integration of community, primary, acute and specialist health care for children (DH, 1999; National Assembly for Wales, 2002; Scottish Executive, 2005, 2005a; WAG 2005, 2005b).
- ◆ Clairevale (2003) emphasises the importance of seeking the views of parents and carers, so that health care professionals can use this information to support and empower parents, carers, siblings and wider family members that help the child/young person.

Organisations involved in providing evidence/rationale range from the Education and Youth Justice Systems, to government sponsored agencies such as Connexions and the National Youth Agency (RCN, 2003d).

**Standard 2**

Ensure that children, young people and their families receive sufficient information, education and support to encourage and enable them to participate actively in all aspects of their care and decision-making.

**Supporting evidence/rationale**

- ◆ It is important to engender a reciprocal relationship with the family, within which each member is able to determine the level of participation they want at any particular time (Kennedy, 2001; DH, 2004c; WAG, 2004; Scottish Executive, 2007).
- ◆ To engender a reciprocal relationship, children, young people and their families require good systems of communication, information, collaboration and support from the multi-professional team (Kennedy, 2001; DH, 2004c; WAG, 2004; Scottish Executive, 2007).

**1.2 Safeguarding children and young people****Standard 1**

Children have a right to be protected, and adults have a responsibility to protect them from harm at all times. In every environment where children and young people are cared for or looked after, there should be a commitment to developing a 'safeguarding culture' that puts the needs of the child/young person as paramount in underpinning that care.

**Supporting evidence/rationale**

- ◆ Infants and small children cannot be independent of adults; they need to be looked after to meet their basic needs, and these needs become greater when children are sick and most vulnerable (DH, 2003a).

The United Nations Convention on the Rights of the Child (1989) states:

**Article 3**

- 1 In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration
- 2 States parties undertake to ensure the child such protection and care as is necessary for his or her well being, taking into account the rights and duties of his or her parents, legal guardians or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
- 3 States parties shall ensure that the institutions, services and facilities responsible for the care and protection of children and young people shall conform with the standards established by competent authorities, particularly in areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Health care systems and processes, policies and procedures need to be in place to support health care professionals' practice in safeguarding children.

- ◆ A safeguarding culture requires robust systems and processes to be put into place (Laming, 2003; Laming, 2009).
- ◆ Safeguarding children policies and procedures should be in place and available organisation wide (Laming, 2003; Laming, 2009; RCN, 2005).
- ◆ Policies should include how to raise concerns about work colleagues (DH, 2004a; RCN, 2005; AWCPP, 2008).
- ◆ A 'designated'\* or 'named' nurse and doctor for safeguarding children should be appointed (DH, 1999, 2003; Carlile, 2002; RCN, 2005; RCPCH, 2006), whose contact details are known throughout the organisation and whose role and responsibilities clearly outlined (DES, 2006; DH, 1999; AWCPP, 2008).
- ◆ In order to prevent miscommunication and gaps in the information shared, a single integrated child health record system, including mechanisms for obtaining records of previous attendances/ admissions from other organisations, should be in place (Laming, 2003; RCN, 2005).

- ◆ A secure facility for storing records in line with Caldicott requirements should be in place (Children [Scotland] Act 1995 [Scotland Office, 1995]; Children [Northern Ireland] Order 1995 [DHSSPSNI, 1995]; DH, 1997; National Assembly for Wales, 2000, and those within the Children Act 2004 [Parliament, 2004] and RCN, 2005a; DH, 2006a, 2009).

### Standard 2

All children's nurses and other nurses who come into contact with children and young people should undertake initial training and annual updating in safeguarding children and young people, commensurate with the nurse's position and level of responsibilities.

#### Supporting evidence/rationale

- ◆ Training in safeguarding children should be included in all pre-registration nursing education and as an integral part of student midwives' curriculum (Carlile, 2002; DH, 2004b; RCN, 2005; HCC, 2007; AWCPP, 2008; Scottish Executive, 2006a).
- ◆ Multi-disciplinary and multi-agency training should be provided to all staff on induction, with a mandatory update as appropriate once a year throughout employment (DH, 2004c; RCN, 2005; AWCPP, 2008; Scottish Executive, 2006a). See also Section 6.5.
- ◆ Child protection work involves making difficult judgments and is demanding and stressful work. All those involved must have access to supervision and support from managers on a frequent and regular basis (DHSSPSNI, 2001).
- ◆ Specialist post-registration education curricula should be available for all professionals working in this field and for selected professionals who take a lead role in safeguarding children and young people (DH, 2004b; RCN, 2005; AWCPP, 2008; Scottish Executive, 2006a).

### 1.3 Transition from children's services to adult services (transitional care)

#### Standard 1

Transition to adult services requires careful planning and collaborative working between the child/young person, adolescent services and adult services. Hospitals and community services should have a clear policy on transition and a pathway of care which maps out the direction(s) young people will take in their transition from children's services to adult services (RCN, 2008).

#### Supporting evidence/rationale

- ◆ The transfer of care from children's/adolescent services to adult services requires special attention and is known as transitional care (DH, 2004c, 2006; WAG, 2003b; Scottish Executive, 2007). A transition should appear as seamless as possible to the young person (RCN, 2008).
- ◆ Transition should be properly planned, and a named key worker appointed to oversee the process and collaborate with other professionals (DH, 2004c, 2006; WAG, 2004; OFMDFM, 2006).
- ◆ There should be a shared protocol between children's and adult services, which is a genuinely shared arrangement and is properly implemented (WAG, 2005a, 2007; RCN, 2008).
- ◆ Evidence of the benefits of planned transition is now emerging (ACT, 2007) and a good transition can improve health-related quality of life for young people with complex health care needs and disabilities (DH, 2008b).
- ◆ The process of transition is expected to take longer where a child has multiple, complex needs, but the key feature of transition is that it should remain 'flexible' at all times (RCN, 2003d; DH, 2004c; WAG, 2005a; DH, 2006).
- ◆ The patient should be involved in the planning and delivery of their own care (RCN, 2003d; DH, 2004c; WAG, 2005b; DH, 2006).
- ◆ There is a lack of adult services for young people with uncommon conditions where medical advances are only recently resulting in significant numbers of survivors into adulthood – for example, congenital heart disease and metabolic diseases. This is because there is little knowledge of these conditions and their treatment in adulthood and few clinicians have acquired the necessary expertise. Young people may therefore remain under the care of children's services and continue to be treated as children, as sometimes the service fails to adapt sufficiently to recognise that the young person is maturing into adulthood (DH, 2003a).
- ◆ A clear policy on transition and a pathway of care will enable the young person, their family and health professionals to understand where the transition process is leading and at what point they have reached (DH, 2006; WAG, 2005a, 2007; Scottish Executive, 2007).

- ◆ This process should be subject to regular review through a clinical audit process (DH, 2006).

### Standard 2

Transition to adult services should not occur until young people have the necessary skills to function in an adult service.

#### Supporting evidence/rationale

- ◆ The Royal College of Paediatrics and Child Health (2002) believe that young people should not be transferred fully to adult services until they have the necessary skills to function in an adult service.

## 1.4 Access to a qualified school nurse

### Standard 1

All school age children and young people should have access to a qualified school nurse. The role of the school nurse should be clearly defined, with a clear remit of responsibilities that will reflect the geographical, social and demographic context within which they work.

#### Supporting evidence/rationale

- ◆ School nurses facilitate the important link between schools/pupils and other health care professionals and agencies (RCN, 2005a).
- ◆ School nurses influence the general health of school age children (primary and secondary) and the healthiness of schools (Scottish Executive, 2003; RCN, 2005a).
- ◆ The RCN believes it to be important that when children are at school, and as part of their development, children should have access to a trusted, impartial professional whom they feel able to approach with questions or concerns (RCN, 2005a)
- ◆ The professional best placed to undertake the role at school should carry out active health promotion and in the first instance this is the school nurse (RCN, 2005a; DH, 2007; Scottish Executive, 2003).

### Standard 2

The school nurse's remit of responsibilities should include:

- ◆ safeguarding children
- ◆ being available with or without appointment for pupils (drop in clinics)
- ◆ health promotion activities
- ◆ screening
- ◆ providing sex education
- ◆ personal, social and health education
- ◆ family support
- ◆ specialised clinics for example smoking cessation, sexual health advice
- ◆ counselling. (RCN, 2005a)

#### Supporting evidence/rationale

- ◆ School nurses are well placed to deliver many of the outcomes for children in the following programmes: *Every Child Matters: Change for Children* (DH, 2004a), *the (English) National Service Framework for Children, Young People and Maternity Services* (DH, 2004c), *Choosing Health* (DH, 2004), *Getting it Right for Every Child* (Scottish Executive, 2005), *Delivering a Healthy Future: An Action Framework for Children and Young People's Health in Scotland* (Scottish Executive, 2007); WAG, 2002, 2004b).
- ◆ In Northern Ireland, it is recognised that school nurses have the potential to be fully involved and to contribute to regional DHSSPSNI strategies (DHSSPSNI, 2006).

## 1.5 Child and adolescent mental health (CAMHS) services.

### Standard 1

All service providers for children and young people will ensure their staff have sufficient understanding of how to assess and address the wellbeing and mental health care needs of children and young people. In addition, all service providers will have robust arrangements in place to secure input from child and adolescent mental health services (CAMHS), including psychiatry, psychology, individual and family psychotherapy, social work, and CAMHS-trained and experienced nurses.

## Supporting evidence/rationale

- ◆ Child and adolescent mental health services promote the mental health and psychological well being of children and young people, and provide high quality, multi-disciplinary mental health services to all children and young people with mental health problems and disorders to ensure effective assessment, treatment and support for them and their families (DH, 2004a).
- ◆ The mental health of the child, young person and their family should be an integral part of all children's services, not overlooked when a physical health disorder takes priority (DH, 2004c; Scottish Executive, 2005b; RCN, 2004a; WAG, 2001, 2005b).
- ◆ The need to support children and young people with mental health problems and disorders is supported in government documents (DH, 2004a; WAG, 2004; Scottish Executive, 2005; Bamford, 2006; DH, 2007).

- ◆ Nurse education: mental health should be incorporated into basic nursing and midwifery education, with mental health concepts introduced early, reinforced and expanded throughout the curriculum, and developed through experiential learning opportunities. Ongoing education is also needed to assist nurses to further develop their knowledge and skills, foster changes in attitudes and beliefs and reorient them from custodial models of mental health care to community-based treatment. Specialist or post-basic education programmes for nurses should be established to ensure that nurses are able to provide services for people with severe mental disorder and provide support to primary care providers.

The areas to include in the education of nurses will depend on the needs of the country, and role of the nurse, current competencies and the resources available. The following is not intended as a comprehensive list of areas of education, but as general guidance when developing education programmes:

- ◆ advocacy
- ◆ assessment of mental disorders
- ◆ communication skills
- ◆ community mental health nursing
- ◆ emotional self-care (i.e. nurses caring for their own mental health)

- ◆ evaluation and research
- ◆ legal and ethical issues, including the understanding of the rights of people with mental disorders
- ◆ management of emergencies (e.g. suicidal behaviour, violence)
- ◆ management of psychotropic medication
- ◆ mental health care in humanitarian emergencies
- ◆ promotion of mental health
- ◆ public health models of mental health
- ◆ stigma and discrimination
- ◆ substance abuse
- ◆ treatment of mental disorders
- ◆ working in teams
- ◆ \*working with service users and their families
- ◆ \*working with specific groups (e.g. children and adolescents, elderly).

Taken from: *Developing nurses resources for mental health Factsheet*, International Council of Nurses (ICN website, 2008).

## Standard 2

- ◆ In children's hospitals and children's units, or hospitals having more than two dedicated wards for children and young people, there will be a minimum of one registered children's nurse who is suitably qualified and experienced in mental health issues and has undertaken an educational programme in child and adolescent mental health. This nurse will provide a lead role with these patients and support other staff in undertaking their care.

## Supporting evidence/rationale

- ◆ The interim report of the review of CAMH services as part of the Children's Plan states:

### Point 4.4

The review has identified that the ambition to improve the mental health and psychological well being of children and young people, does not have a sustained and consistent priority, focus and understanding throughout all services for children and young people. This applies at national, regional and local levels. (DH, 2008a).

## SECTION 2. Preventing hospital admission: day care and community-based services

### 2.1 Admission of children and young people to hospital

#### Standard 1

Children and young people should not be admitted to hospital unless appropriate care cannot be given in the community. Where the care they require can only be provided in a hospital setting, the duration of their stay should be as short as possible and the opportunity given for a parent or carer to accompany them (Platt Report, 1959; DH, 1991).

#### Supporting evidence/rationale

- ◆ Early research supports the need for parental support in hospital. In *Attachment, separation and loss* (1973), Bowlby theorised that in infancy and very early childhood, attached behaviour, where young children were kept within reach of their mothers, was instinctive, an evolutionary protection mechanism for the survival of the young. The breaking of the attachment bond, or separation, was too dangerous to the psychological well being of the child, and if such a separation became permanent, then the child could be seen to grieve for that loss.
- ◆ Bowlby and James Robertson together described three stages of such grieving - protest, despair and detachment (Robertson, 1953a). At first Robertson named the third stage 'denial' (Robertson, 1953b), but Bowlby coined the term 'detachment' (1973) because he argued that it fitted better with his concept of attachment.
- ◆ The three stages that a child goes through when it is separated from its parents are: the child first protests on being left, and cries for its mother; then the child begins to withdraw as it despairs, cries sometimes, sits quietly with others, but is still able to be distracted if someone comes to talk or play; the final stage occurs when the child has given up hope of being taken home, and is characterised by a detachment from the everyday environment, and from people, including their parents when they come to visit.  
(Cited in: Shields and Nixon, 1998)

- ◆ Children's best interests are served on the whole by being in hospital for the briefest possible time needed to provide safe and effective treatment (DH, 1991, 2004c).
- ◆ In a study by Diaz-Caneja et al. (2005) it was concluded that admission of a child to hospital is stressful for both the child and parents, particularly if the child is admitted to a paediatric intensive care unit (PICU). Hospital staff should enhance communication with parents and maximise opportunities for parental participation in the child's care. Such intervention may reduce parents' stress during the admission and has the potential to improve the psychological outcome to both child and parents.
- ◆ The child/young person admitted for day surgery needs careful consideration by all staff, (Thornes, 1991). Thornes' document, although published some time ago, remains an important document. It contains 12 'quality gold standards' with 42 principles for all paediatric day case admissions, and provides a planned package of care incorporating the quality care standards.

#### Standard 2

If a child needs admitting to hospital for planned surgery, this should wherever possible be done on a day-care basis, with ongoing care and support provided at home from the community children's nursing team.

#### Supporting evidence/rationale:

- ◆ Children should not be admitted to hospital unless appropriate care cannot be given in the community. Day surgery is at the centre of government guidance (DH, 1991, 2003a; DHSSPSNI, 1995; Platt Report, 1959; Scottish Executive, 2007; Scottish Office, 1993, 1995; WAG, 2004; Welsh Office, 1991, 1997a).

### 2.2 The recognition and assessment of acute pain in children

#### Standard 1

Children's nurses must be able to competently recognise and assess levels of pain in both communicative and non-communicative children and young people. They should use a reliable, valid pain assessment tool which is appropriate to the child's stage of development, and administer analgesic drugs and other non-drug interventions in order to reduce/eliminate pain.

The following should be in place to enable nurses and other health care professionals to accurately assess and manage pain in children/young people:

- ◆ evidence-based policies and procedures on the assessment and management of pain, derived from national clinical guidelines
  - ◆ a valid and reliable pain assessment tool for the child/young person (note that in some areas where a wide range of ages of children are cared for, more than one pain assessment tool may be required)
  - ◆ models including pain assessment of cognitive-impaired children, paediatric pain profile (PPP) and the non-communicative children's pain checklist postoperative version (NCCPC – PV) (Hunt et al., 2008)
  - ◆ a range of pain-relieving interventions (analgesic drugs and non-drug methods)
  - ◆ patient/parent information leaflets
  - ◆ a competency-based education programme for nurses
  - ◆ regular clinical audit of pain assessment and management practices.
- (DH, 2004c; WAG, 2004; Scottish Executive, 2006a; HCC, 2007)

#### Supporting evidence/rationale:

- ◆ If pain is not properly assessed or pain-relief not given promptly, pain can be unpleasant, delay recovery and add to the upset caused by illness, injury or clinical procedures (HCC, 2007).
- ◆ Children and their parents must be involved in the decision-making process about pain management strategies. For example, a child may be more willing to complete a pain scale if they understand that by doing so, their pain can be taken away or reduced (RCN, 1999).
- ◆ Non-drug interventions can be effective in reducing pain in children. These include acupuncture, TENS, distraction methods and so on. See Twycross (2009) for a summary of the research evidence relating to non-drug methods of pain relief for children.

#### Standard 2

There should be at least one registered children's nurse per shift trained to administer 'first line' pain relief (such as ibuprofen and paracetamol) according to agreed protocols (HCC, 2007).

#### Supporting evidence/rationale

- ◆ This means that once an assessment of pain has been properly completed, pain relief can be given to a child without waiting for medical authorisation.
- ◆ Many children are not as able as adults to communicate their pain, which can mean health care professionals underestimate the level of pain a child is experiencing.

If the nurse has not been trained they will not be able to assess or administer pain relief; the child will remain in pain.

### 2.3 Consent

#### Standard 1

The process of giving or withholding consent should apply to all surgical procedures, clinical procedures and examinations that involve any form of touching (Kennedy, 2001). Children, young people and parents need valid, relevant, accurate, current, easily accessible and well-presented information, appropriate to their level of understanding, before they make their decision to consent to a procedure.

#### Supporting evidence/rationale

- ◆ The NMC Code (2008), states that in caring for patients and clients, nurses must obtain consent before they give any treatment or care.
- ◆ Obtaining consent for treatment should be a process of communication between the professional, patient and parent/carer, not a one-off event to obtain a signature on a form in order to proceed (Kennedy, 2001).
- ◆ Children, young people and the parents/carers need to be told about what will take place, any risks and uncertainties, and any possible consequences of the proposed treatment; they should be given the alternatives and the likely outcome of the treatment in order for them to proceed to make their decision (DH, 2001; Kennedy, 2001; Scottish Executive, 2006; WAG, 2008a).

- ◆ Children, young people and the parents/carers should also be directed to information relating to the performance of the hospital, the specialty and the consultant involved in the patient's proposed care or treatment (Kennedy, 2001).
- ◆ All professionals involved must be knowledgeable about the concept of 'competence' in giving consent, particularly by the child or young person, and the relationship between the child's age, level of understanding, and physical and cognitive level of development (DH, 2003a; WAG, 2005, 2008a; Scottish Executive, 2006).

### Standard 2

Consent policies should clearly outline the options of what to do when there are differences of opinion between a competent young person and parent, or when a parent refuses to give consent to a life-saving intervention for the child/young person.

#### Supporting evidence/rationale

- ◆ Everyone has the right to have the full and complete information about themselves and any treatment or care programme they are about to embark upon (DH, 2001). This applies to children and young people of all ages.
- ◆ Everyone has the right to give, withhold or withdraw his or her consent at any time (Kennedy, 2001; DH, 2001, 2004c; WAG, 2005, 2006, 2008a; Scottish Executive, 2006).

## 2.4 Nursing children in community settings

### Standard 1

All children and young people should have access to qualified community children's nurses when the care they require can be given either at home or in other community-based settings.

#### Supporting evidence/rationale

- ◆ Community children's nursing (CCN) teams can care for children with a wide range of care needs, including:
  - ◆ long-standing physical illness, e.g. diabetes, asthma
  - ◆ learning disabilities
  - ◆ life-limiting illness, e.g. cystic fibrosis, congenital heart disease, cancer
  - ◆ dependence on technology/equipment, e.g. tracheostomy, gastrostomy
  - ◆ neonatal and post neonatal care
  - ◆ following planned or emergency surgery. (RCN, 2003c)

- ◆ Research has demonstrated that when a child is cared for at home, the family adjust more quickly to a long-term illness, home care is a more effective use of resources, and that care is individualised to the family lifestyle (Anderson, 1990).
- ◆ The Welsh Assembly Government (2005), in looking at dynamic new approaches to the delivery of care, supports community resources such as nursing care delivered by appropriately skilled individuals.
- ◆ Children's community nursing services are well placed to deliver palliative care for those children and young people living with life-limiting illness (Maunder, 2006; DH, 2009b).

## 2.5 Equal access to specialist palliative nursing care

### Standard 1

All children or young people with a life-limiting illness have the right to have the very highest professional standard of care, in both primary and secondary care settings.

There are over 20,000 children and young people in England with conditions likely to require palliative care and around 4,000 deaths a year. About 1,800 children each year potentially require end of life care at home or in a hospice. (Cited in DH, 2007a).

#### Supporting evidence/rationale:

- ◆ A paediatric palliative care network should actively address issues of equitable access to palliative care (NICE, 2005; NGCH, 2006).
- ◆ Improving the quality of palliative care for children and young people and their families is recommended in the *National Service Framework for Children, Young People and Maternity Services (England)*, and there is evidence to suggest that there is scope for these needs to be met more systematically, such as in *Voices for change*, a survey by the Association for Children's Palliative Care (ACT, 2009).

- ◆ In order to commission effective palliative care for children and young people, it is important to understand the nature of the life-threatening and life-limiting illnesses which may affect them and the ways in which children's palliative care needs may differ from those of adults (ACT, 2009).
- ◆ Depending on the child's underlying disease or condition, the care pathway is often a complex one. The number of children and young people dying is small but their need for palliative care involves much longer-term provision, often intermittently throughout their lives (ACT, 2009; Scottish Government, 2009).

### Standard 2

Children's nurses practising in palliative care, whether in hospital, hospice or home, require a high level of knowledge, skill and experience to work with these children and families. There should be agreed nationally by each country, standards for education and practice for nurses working in this specialty.

A competency-based education programme is needed for nurses working in palliative care encompassing:

- ◆ the assessment of pain, including pain assessment tools
- ◆ the management of pain using analgesic drugs and non-drug methods
- ◆ the assessment and management of other symptoms
- ◆ communicating with children and their families
- ◆ misconceptions regarding palliative care in children. (HCC, 2007; Dowden, 2009)

### Supporting evidence/rationale

- ◆ Specialist palliative care provides relief from suffering and improves the quality of life for the patient and their family during the final stage of illness (ACT, 2007).
- ◆ Palliative care provides a holistic approach, acknowledging that the patient requires a complex combination of physical, psychological, social and spiritual care, depending upon the child/young person's level of understanding and development. This can be effectively delivered through integrated multi-agency care pathways (ACT, 2007).

- ◆ Key recommendations in a Northern Ireland review of palliative care services, including that delivered to children, in 2000 showed the need for provision of specialist advice and support, and the development of children's community nursing services. The importance of developing a team approach was highlighted with an emphasis on the appropriate training of staff (DHSSPSNI, 2000a).

## SECTION 3: The care environment and facilities for children, young people and their families

### 3.1 Children should not be nursed in adult environments

#### Standard 1

Children and young people should be cared for in the most appropriate environment that effectively and sensitively meets their needs. Efforts should be made to achieve this at all times.

#### Supporting evidence/rationale:

- ◆ Children should not be nursed in adult environments (DH, 1991, 2003a; Welsh Office, 1991; WAG, 2004; DHSSPSNI, 2004; Scottish Executive, 2007).
- ◆ Children should be treated in separate facilities, away from adults, wherever possible (WAG, 2004; HCC, 2007).

#### Standard 2

Child-friendly accommodation in a purpose-designed children's ward or department should be provided. This should include a defined area that can be separated off to accommodate the privacy of young people and their visitors (HCC, 2007).

#### Supporting evidence/rationale:

- ◆ Children are not "mini-adults" (Kennedy, 2001). Facilities should be designed to meet their specific needs and children/young people should be involved in the planning and development of future services (RCN, 2003b).

- ◆ The hospital standard (DH, 2003a) states that the care of children and young people in hospital should be provided in buildings that are accessible, safe, and suitable and child- and family-friendly (DH, 2003a; HCC, 2007).
- ◆ Adapting existing adult accommodation often falls short of the required standard (Kennedy, 2001).

### Standard 3

When children and young people are in-patients on an adult ward, a designated senior children's nurse should be available 24 hours per day to provide advice on nursing care and support. Registered children's nurses should be deployed to work alongside nurses in the adult environment to provide care for the child/young person.

#### Supporting evidence/rationale:

- ◆ If a child or young person is admitted to an adult ward or unit, a senior children's nurse should be available to provide advice to those nurses who are responsible for the delivery of direct care and registered children's nurses should be deployed to work alongside nurses in the adult environment in the care of the child/young person (RCN, 2004a).
- ◆ Senior children's nurses will also have a remit to provide advice and support across the organisation, in all areas where children and young people are seen or cared for. They will have responsibility for ensuring that the organisation's clinical governance strategy, systems and processes are attentive of the special needs of these client groups (DHSSPSNI, 2000; DH, 2003a; WAG, 2003b, 2004a; RCN, 2004a; HCC, 2007).
- ◆ The acute hospital standard of the *National Service Framework for Children, Young People and Maternity Services* (DH, 2004c) and Kennedy (2001) reinforce the need for children and young people to be cared for by staff that have the right knowledge, expertise and skills to meet children's specific needs.
- ◆ Adult qualified nurses and other professionals who come into contact with children and young people as part of their working day need access to experienced and appropriately qualified senior children's nurses who can offer support, advice and ensure /oversee and monitor the well being of this client group (WAG, 2004a).

## 3.2 A separate area in operating department reception and recovery areas

### Standard 1

Children and young people scheduled for surgery should be cared for in an environment that is suitable to their age and level of development, i.e. child-friendly designated reception and recovery areas.

#### Supporting evidence/rationale

- ◆ At all times efforts should be made to nurse children and young people in an environment that effectively and sensitively meets their needs (DH, 1991; Welsh Office, 1991; WAG, 2004; RCN, 2003b; 2004).
- ◆ The area should be safe and well suited to the age and stage of development of the child/young person (DH, 2003a; WAG, 2004).
- ◆ There should be appropriate play facilities (DH 2003a; WAG, 2004).

### Standard 2

There should be the opportunity for the parent or carer accompanying the patient into the anaesthetic and recovery area. They will need to wear theatre attire which is considered suitable by the theatre manager and infection control team.

#### Supporting evidence/rationale

- ◆ A parent/carer should be encouraged to accompany the child/young person into the anaesthetic room until they are asleep. Parents/carers should be invited into the recovery area and accompany the ward nurse on the journey back to the ward (RCN, 2004).
- ◆ If children and young people must be cared for on an adult day care unit, a specific area for them and their parents/carers must be provided, and separate sessions and/or facilities provided (DH, 1991; DH, 2003a; Scottish Office, 1993; DH, 2004c).

## 3.3 The use of single rooms based on clinical need

### Standard 1

An evidence-based policy should outline the prudent and priority order for occupation of single rooms/cubicles in specialist units or children's wards, so that the rooms available are used effectively and optimally for those patients who clinically require them.

### Supporting evidence/rationale

- ◆ Effective infection control practice supports the use of single rooms/cubicles for clinical reasons. This may be for source isolation to prevent the spread of infection, or for protective isolation to protect the more vulnerable from infection (DH, 2008; Chaib, 2007).
- ◆ Other reasons for single room occupancy include the acuity/dependency of the patient needing one-to-one nursing care, and the age and special needs of the child or adolescent (RCN, 2002).
- ◆ The availability of single rooms for isolating patients is of particular value to control outbreaks of infection and for babies and children whose immunity is compromised and need to be protected against the possibility of contracting a nosocomial or health care associated infection (DH, 2008).
- ◆ Where possible, single rooms should have hand washing, toilet and bathroom facilities to help support infection control.
- ◆ An isolation capacity tool enables hospitals to understand the capacity demands that infections place upon them. A side room/isolation calculator estimates the number of hospital side rooms/beds needed for infectious and other patients (DH, 2008).
- ◆ A strategy that allocates available rooms on evidence-based, clinical priority serves well to provide a system of rational allocation based on clinical need rather than fanciful action. The senior nurse on duty will enforce the policy in practice (DH, 2008).

### 3.4 Recognise and use the valuable knowledge and caring experience of parents and carers

#### Standard 1

Children and young people have the right to have a parent or carer present with them at all times, if this is their wish, including overnight stay in any environment where they are cared for (RCN, 2003b).

#### Supporting evidence/rationale

- ◆ Suitable accommodation should be provided for a family member that affords them privacy, dignity, security and independence (RCN, 1998).
- ◆ The needs of breastfeeding mothers and of their infants should be given special attention, including being given access to a nutritious diet and adequate fluids (DH, 1995, 2004c; RCN, 1998; WAG, 2002).

- ◆ Children and young people show signs of distress when they are admitted to hospital, leaving the comfort, safety and security of their familiar environment and of significant family members. This disruption and distress for the whole family should always be minimised (Diaz-Caneja et al., 2005). A child should only be admitted to hospital if the care they require cannot be provided at home. Encouraging a parent or carer to stay with them in hospital will minimise the distress and accelerate recovery (Kennedy, 2001).

#### Standard 2

When parents or main carers are present and wish to participate in the care of their child they should be encouraged to do so. Care should be negotiated with them and their child and reviewed on a regular basis. This dialogue should be documented as an aid to communication between the nursing team.

#### Supporting evidence/rationale

- ◆ Hospital staff should enhance communication with parents and maximise opportunities for parental participation in the child's care, thus potentially improving the psychological outcome for child and parent (Diaz-Caneja et al., 2005).
- ◆ The United Nations Convention for the Rights of the Child (1989) states that children have a right to be involved in decisions about their care: they need to be given information in a way they can understand, along with suitable choices, which will vary according to their stage of development.
- ◆ In the Healthcare Commission's survey of young patients, 47% of respondents said they were not involved in decisions as much as they wanted during their stay in hospital (HCC, 2007)
- ◆ The Welsh NSF (WAG, 2004, p112) for children states: "Children receive care centred on their particular needs. All children, young people and parents/carers receive support and information to enable them to understand their condition, treatment and care and are encouraged to be active partners in decisions that affect them. Their care is well co-ordinated across the various providers and systems, with a clear point of contact for the key elements of support."

### 3.5 Nursing documentation and record keeping

#### Standard 1

It is important to maintaining a high standard of record keeping at all times to ensure the effective assessment, delivery, and evaluation of patient-centred care. The standard of nursing documentation plays an important part in the overall management of the patient's care.

#### Supporting evidence/rationale

- ◆ The content and quality of the record keeping are a measure of standards of practice, skills and judgement of the nurse (NMC, 2005). Nurses have a professional responsibility to ensure that health care records provide an accurate account of treatment, care planning and delivery and are viewed as a tool of communication within the team. There should be clear evidence of the care planned, the decisions made, the care delivered and the information shared (NMC, 2005, p8).

“The Quality of a registrant's (nurse's) record keeping is a reflection of the standard of their professional practice. Good record keeping is a mark of a skilled and safe practitioner, while careless or incomplete record keeping often highlights wider problems with that individuals practice.”

NMC (2005).

- ◆ Record keeping and computer held records: many nurses are now regularly using information technology to record the planning, assessment and delivery of care. There are obvious advantages to this. Computer-held records tend to be easier to read, less bulky, reduce the need for duplication and can increase communication across the inter-professional health care team. There is no requirement to keep manual duplicates of computer held records and they do not replace the need to maintain dialogue through the inter-professional health care team. Safeguards for computer held records must be in compliance with the Computer Misuse Act 1990.

- ◆ Accountability and electronically held records: nurses are accountable for an entry they make to electronically held records and must ensure that any entry made by them is clearly identifiable. Shared passwords are unacceptable, as any entries made by nurses will not be individually identifiable. As with manual held records, the use of abbreviations is not recommended (NMC, 2005).

“The approach to record keeping that courts of law adopt tends to be that ‘if it has not been recorded, it has not been done’. Registrants are required to use their professional judgment to decide what is relevant and what should be recorded. This applies particularly to situations where the condition of the patient is apparently unchanged and no record has been made of the care delivered.”

The NMC (2005)

### 3.6 Caring for adolescents

See also Section 1.3

#### Standard 1

A ‘designated area’ for accommodating young people, which is designed to meet their special needs, including providing privacy when they receive visitors, should be provided. An adolescent unit, or designated area of a children's ward or adult ward (depending upon the level of their development and their choice) is ideal (DH, 1996, 2004c).

#### Supporting evidence/rationale

- ◆ Young people have distinct needs from those of children and adult patients (DH, 2003a).
- ◆ *The National Service Framework for Children, Young People and Maternity Services* (DH, 2003a, p36) states: “Facilities should be designed to meet the specific needs of children and young people and they should be involved in the planning and development of future services” (RCN, 2003b).
- ◆ A study carried out by Norwich Union (2001) identified young people as expressing the need for specialised units that accommodated their needs.

- ◆ An intercollegiate report published by the Royal College of Paediatrics and Child Health (RCPCH, 2002) sets out principles of best practice when setting up services for young people.

### 3.7 Meeting educational needs of children and young people in hospital

#### Standard 1

During admission to hospital, children and young people should be able to continue with their school activities and education to the degree that they are able to or wish to.

#### Supporting evidence/rationale

- ◆ While in hospital, children and young people who are well enough should have their educational needs met by hospital schools (DH, 1991; RCN, 2003b; WAG, 2004a).
- ◆ School activities and education can also be a means of distraction children from worrying thoughts of treatment or impending procedures. They are also a means of expression. Importantly, continuation of education particularly in adolescence is a means of maintaining academic attainment and preventing falling behind, especially if a long programme of treatment is required (DH, 1996; Welsh Office, 1997; DH, 2001).

### 3.8 The importance of play in health care settings

#### Standard 1

All children and young people should have access to play and hobby materials, and there should be experienced staff to oversee play activities.

#### Supporting evidence/rationale:

- ◆ Children visiting or staying in hospital have a basic need for play and recreation that should be met routinely in all hospital departments which serve children; this equally applies to patients' siblings (DH, 2003a; HCC, 2007; Action for Sick Children, 2006).

#### Play in hospital

- ◆ creates an environment where stress and anxiety are reduced
- ◆ helps the child to cope with illness and hospitalisation
- ◆ helps the child to regain confidence, independence and self esteem
- ◆ provides an outlet for feelings of anger and frustration
- ◆ helps the child to understand treatment and illness
- ◆ aids in assessment and rehabilitation reduces the need for sedation for some procedures.

(Taken from *Play for health developing and auditing quality in hospital play services*, NAHPS, 2006.)

- ◆ In Northern Ireland, a multidisciplinary regional inspection of the service for disabled children in hospital (DHSSPSNI, 2005) emphasised the importance of play, music and art therapy for those children and young people who spend extended periods of time in hospital.
- ◆ It is recommended that all children staying in hospital have access to a play specialist (DH, 2003a; WAG, 2004).
- ◆ Play can be used in a variety of ways, to assess levels of growth and development, to play out or assimilate new information and experiences, prepare to cope with procedures and interventions (DH, 2004c; WAG, 2004), to play out fears and feelings, and to act as a distraction or to empower and heal.
- ◆ The use of play techniques should be encouraged across the multidisciplinary team caring for children, including in accident and emergency departments. Play specialists should take the lead in developing techniques that other staff can follow (DH, 2003a; WAG, 2004).
- ◆ All children and young people need to express their needs and feelings and do so in different ways. Play is an important, child-centred communication tool when it is viewed not just as fun but as a language in its own right (Webster, 2000).

- ◆ The team should be able to offer a variety of play interventions to support the child at each stage of their journey through the hospital system (DH, 2003a; WAG, 2004).

## SECTION 4: Keeping the environment safe for children, young people and their families

### 4.1 Managing risks in environments where children and young people are cared for

#### Standard 1

A key responsibility of children's nurses is to provide a safe environment for children, young people and their families, both in health care settings and wherever possible, in community settings.

#### Supporting evidence/rationale

- ◆ The NMC code of professional conduct (2008) states: "You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk", and: "You must report your concerns in writing if problems in the environment of care are putting people at risk."
- ◆ Children are more vulnerable than most adults and have a greater need for their welfare to be safeguarded (DH, 2003).
- ◆ While a child patient is in hospital, the hospital has a duty of care towards the child. This means the hospital has a responsibility to provide an environment where the child is safe and to protect them from harm at all times. The duty of quality placed on organisations is described in Section 18 of the Health Act 1999 (Parliament, 1999).

### 4.2 A safe and secure environment

#### Standard 1

Maintaining a safe and secure environment for children and young people is essential at all times. This covers the physical environment, the staff who work within it, and safe systems and processes that support staff and protect patients and the public.

#### Supporting evidence/rationale

- ◆ Organisations have a duty of care to ensure safe systems are in place (RCN, 2001; DH, 2004c; WAG, 2004). (See also Standard 4.1)
- ◆ Policies and procedures should be in place to inform staff of the importance of security and to develop a culture of conscientious challenge when policy is not followed (RCN, 2001; DH, 2004c; WAG, 2004).
- ◆ An integral part of these policies and a high priority for NHS organisations is the clear identification of staff working with children and young people. Staff should be identified by wearing a NHS (or company) identification badge at all times while on duty. There should be a culture of staff challenging others when they do not comply (RCN, 2001; DH, 2004c; WAG, 2004).
- ◆ All areas where babies, children and young people are cared for should be security controlled with the use of swipe cards and CCTV systems which can identify the identity of people using the card to gain access (RCN, 2001).

### 4.3 Using medical devices and healthcare products safely

#### Standard 1

All children's nurses should learn about the safe use and management of medical devices and health care products in any of the clinical areas they may work in. This is particularly important for bank or agency staff. Nurses should refuse to operate medical devices that they have not been adequately trained to use.

#### Supporting evidence/rationale

- ◆ Clear policies need to outline an organisation's training requirements.
- ◆ Training is a key element in medical device safety to ensure the practitioner can competently use the device, can interpret its data and act promptly in the event of malfunction (MHRA, 2006).
- ◆ Nurses should undertake training and annual updates when medical devices/products have been modified or upgraded to new models (MHRA, 2006).

- ◆ Accurate records of training should be kept by both the nurse and their line manager, to enable monitoring of uptake of training and to ensure patient safety (MHRA, 2006).

### Standard 2

All medical equipment should be the correct size and specification for use on children. Its design must be tailored to meet the different needs at different ages and stages of development

#### Supporting evidence/rationale

- ◆ The equipment must be safe and fit for purpose commensurate with the size/weight and level of development of the child/young person (Kennedy, 2001; WAG, 2004; DH, 2004c).

## SECTION 5: Employment, staffing levels and skill mix

The effective use of the nursing resource in order to ensure children and young people receive the highest standard of care

### 5.1 Recruitment and selection of staff working with children and young people, including volunteers and student nurses, to ensure patient safety.

#### Standard 1

All staff employed to work with children or young people should only be allowed to do so following a rigorous and satisfactory recruitment and selection process.

The recruitment process should include:

- ◆ advertisement, job description, person specification and selection
- ◆ checks to confirm authenticity of qualifications to ensure that nurses have undertaken and successfully completed the appropriate educational programme and have effective registration with the appropriate regulatory body. See: [www.nmc-uk.org](http://www.nmc-uk.org)
- ◆ checks on criminal record<sup>†</sup> (WAG, 2005c)
- ◆ checks where application forms show employment/education gaps (RCN, 2001)

- ◆ for newly qualified nurses, references obtained from a university lecturer
- ◆ for other nurses, references obtained from two previous employers, one being the most recent employer ‡
- ◆ pre-employment occupational health checks and obtaining a medical report from a GP if necessary (Clothier, 1994; RCN, 2005; WAG, 2005d; see also ISA website.)

Recruitment online now leads to the provision of electronic references, but these may not always readily provide the information required (RCN, 2001). Electronic staff records makes the process easier for checking employment details of staff who have already been employed in the NHS. Where the employment has been outside the NHS or overseas, then the use of references is critical. All requests for references should be made to the previous employer's human resources (HR) department.

#### Supporting evidence/rationale

- ◆ Staff employed to work with children and young people are expected to provide evidence that they are appropriately qualified, are fit to undertake the required role and responsibilities, come recommended for this area of clinical practice based on previous employment performance, and are known to be of the highest integrity (Clothier, 1994; RCN, 2001; Bichard Inquiry, 2004; WAG, 2005d).
- ◆ All agencies and organisations whose staff, volunteers or foster carers work closely with children should have policies and procedures in place to ensure they engage those who are most suitable to work closely with children (DHSSPSNI, 2001, Scottish Executive, 2003a, 2006b; WAG, 2005c).

<sup>†</sup> Criminal records should be checked via the country's appropriate authority: Criminal Record Bureau (CRB) disclosure (England and Wales); Disclosure Scotland (Scotland); Protection of children (POC) (NI) service check (Northern Ireland)

<sup>‡</sup> Denotes an officer of the organisation who has line management responsibility for the employee and has the organisation's authority to provide an employment reference on hospital headed notepaper.

## 5.2 A knowledgeable and experienced senior nurse to oversee and develop services for children and young people locally

### Standard 1

The appointment of a senior registered children's nurse will influence the commissioning and management of children's and young people's services in each health care organisation locally. This individual will be able to speak eloquently and confidently about the needs of children and young people and, through their influence, will have credibility with key decision-makers.

#### Supporting evidence/rationale

- ◆ All health organisations should have a senior children's nurse as an equal partner with the service manager and a lead paediatrician in the management of children's services (RCN, 2004a; WAG, 2004a).
- ◆ By 'senior', the RCN (2004a) refers to a registered children's nurse who is an equal partner with the service manager and lead paediatrician and can demonstrate their credibility and competence. A senior nurse will have a minimum of five years experience post qualification in children's services, will be able to show evidence of continuing professional development and achievement, and hold a Masters degree, ideally in a health or management subject.
- ◆ The RCN endorses the need for a designated professional who has children and young people's health experience and expertise to be responsible for commissioning services at local level (RCN, 2003b; WAG, 2004a).
- ◆ Senior children's nurses will have knowledge about what a good level of care is for children, and ensure that all children receive it (RCN, 2004a; WAG, 2004a).

### Standard 2

The senior children's nurses will be involved in all decision making about the delivery of services, including business planning and service development, and will have a say in the allocation of financial resources.

### Standard 3

Each hospital executive board will have a designated director for children's services who will liaise regularly with the senior children's nurse to ensure the board is well briefed on issues of importance (RCN, 2004a; HCC, 2007).

#### Supporting evidence/rationale

- ◆ A senior children's nurse will be able to use their professional knowledge and experience to influence senior staff and managers. They will be able to communicate articulately and effectively with other senior managers and board-level directors on issues of importance for children and young people and areas of potential vulnerability for the organisation (RCN, 2004a; WAG, 2004, 2004a).
- ◆ Senior children's nurses will also have a remit to provide advice and support across the organisation to all areas where children and young people are seen or cared for. They will have responsibility for ensuring that the organisation's clinical governance strategy, systems and processes recognise the special needs of these client groups (DHSSPSNI, 2000; DH, 2003a; WAG, 2003b, 2004a; RCN, 2004a; HCC, 2007).

## 5.3 Developing a nationally (internationally) accepted staffing and skill mix formula

### Standard 1

Each organisation should follow a nationally (internationally) accepted, objective and rational formula for staffing and skill mix in all environments where children are seen and cared for. This formula along with the senior children's nurses professional judgement should determine the specialty-specific nurse:patient ratios which underpin the delivery of safe and effective high quality care.

#### Supporting evidence/rationale

- ◆ Ensuring appropriate staffing levels and skill mix to optimise the standard of care children and young people receive, regardless of time and location, and provide equity and equality of service provision across the UK (Kennedy, 2001; RCN, 2001; DH, 2004c; WAG, 2004, 2004a; DHSSPSNI, 2005; Scottish Executive, 2007).
- ◆ *The National Service Framework for Children, Young People And Maternity Services* (DH, 2004c), the Welsh Assembly Government (2004) and the Scottish Government (Scottish Executive, 2007) emphasise that children and young people should receive appropriate high quality, safe, evidence-based care which is developed through clinical governance and delivered by staff who have the right set of knowledge and skills.

- ◆ The Auditor General (Scotland) (2002) highlighted a lack of workforce planning and integrated planning, and found these factors as central to optimal, cost-effective nurse staffing levels. In the Executive Summary, the Report states: “Across trusts we found wide variations in nursing establishments among the six ward types included in the study. In the absence of national guidance for staffing on these types of wards, differences can be expected. Some variation is likely as a result of differing patient needs, although this is unlikely to explain the full extent of variation.”
- ◆ A large scale national study conducted by Rafferty et al. (2006) found that patients and nurses in hospitals with the most favourable staffing levels have better outcomes than those in less favourably staffed hospitals.
- ◆ Care by staff who have received specific training to meet the needs of a particular client group undoubtedly influences the quality of care received (DH, 1991; Kennedy, 2001; RCN, 2003; WAG, 2003, 2005a).
- ◆ The professional judgement of nurse managers provides a reliable basis for decisions about the nursing establishment on a ward and the skill mix. They understand, for example, local patterns of patient throughput, dependency levels, ward layout and the requirements of medical and surgical teams. They should be encouraged to restrict extra or emergency ward admissions according to available staff and skill mix if they feel patient safety might be compromised by (RCN, 2003e).

Several factors influence staffing levels and skill mix and as these factors change, the staffing and skill mix should be reviewed; for example, if there is a change in dependency/acuity levels of patients or a change in the care delivery model (RCN, 2003).

## 5.4 Knowledge, skills and competence of nurses working with children and young people

### Standard 1

All nurses who provide care to children and young people should have a specific qualification in the nursing care of children and young people.

### Supporting evidence/rationale

The NMC Code states:

- ◆ You must have the knowledge and skills for safe and effective practice when working without direct supervision
- ◆ You must recognize and work within the limits of your competence
- ◆ You must keep your knowledge and skills up to date throughout your working life
- ◆ You must take part in appropriate learning and practice activities that maintain and develop your competence and performance.

(NMC, 2008)

- ◆ The RCN (2004a) recognises that children, young people, families and the public can expect that nurses, doctors and other professionals who are responsible for children and young people's health care will be appropriately qualified and experienced.
- ◆ Any nurse working with children without specific training, is working outside their registration status (RCN, 2003a). Non-registered children's nurses must work alongside/under the supervision of a registered children's nurse when providing care to a child or young person.
- ◆ Regulatory requirements, government policy and guidance – from the Platt Report (1959) through to Kennedy (2001) and Carlile Reports (2002) – all require that staff involved in the care of children and young people should have specific training to meet the special needs of this group (RCN, 2003a).

### Standard 2

All nurses working with children and young people should have the knowledge skills and competence in the following areas:

- ◆ recognising and understanding the individuality, rights and resilience of children, young people and their families in all areas of the health care system
- ◆ acting within country-specific legislation and adhering to relevant professional codes and local policy and guidance
- ◆ communicating with children and young people to understand their needs, involving them and their parents/carers in decision-making and facilitating children to care for themselves as much as they are able to or wish to

- ◆ assessing children and young people in terms of their clinical needs, based upon knowledge of different stages of physical, intellectual and emotional development and delivering that care effectively
- ◆ recognising actual and potential physical health, mental health and social care problems and deterioration in health status
- ◆ recognising when a child/young person is in pain by using a reputable paediatric pain assessment tool and taking appropriate action
- ◆ basic paediatric life support
- ◆ safeguarding children and young people, recognising signs and situations that indicate abuse or neglect, knowing how to act to safeguard a child and seek the appropriate help and advice
- ◆ recording assessments of care, and effective communication with the child health team, involving child/young person and their parents/carers
- ◆ managing the care of the child/young person within and across integrated service teams and liaising with external agencies effectively.  
(Kennedy, 2001; RCN, 2003a, 2007).

#### Supporting evidence/rationale

- ◆ Acknowledgement that children and young people are in a developmental stage of their lives and require care which is significantly different from adults, and should be provided by those who have had received specific educational preparation to meet their distinct needs (United Nations, 1989; DH, 2001, 2003a, 2004a; DES, 2006; Scottish Executive, 2005; WAG, 2005).
- ◆ There are variations in the four countries' policies, so practitioners must recognise and comply with their own country's requirements.
- ◆ Education and continuing professional development is a process of lifelong learning for all individuals which enables them to grow and develop as practitioners as well as to continue to adapt to meet the needs of children and families (RCN, 2001)
- ◆ Nurses caring for children and young people who cannot demonstrate their knowledge and competence would be in breach of their Code of Practice (NMC, 2008).

## 5.5 Nursing establishment and skill mix

### Standard 1

Several basic principles apply to the nursing establishment and skill mix in all areas where children/young people are cared for:

- ◆ there should always be a minimum of two registered children's nurses on duty 24-hours-a-day in such wards/units
- ◆ the nursing establishment should also allow for a shift supervisor to coordinate the operational and clinical management of the ward/unit and to include the delivery of care to a small patient caseload
- ◆ 25% additional time allowance should be incorporated into the establishment for un-worked hours including sickness, annual leave, absence, training and development
- ◆ specialist nursing posts (such as nurse practitioner, clinical nurse specialists or advanced nurse practitioner) should be calculated in addition to the required ratios of registered nurses:patients. This is because senior nurses often undertake expert clinical decision-making and care, as well as undertaking teaching, education and research
- ◆ staffing levels for neonatal and paediatric intensive care retrieval/transfer services should be separate from the clinical inpatient service, so that the care of babies, children and young people is not compromised by unpredictable staffing requirements (DH, 2003b; WAG, 2003a).  
(Kennedy, 2001; BAPM, 2001; RCN, 2003e; DH, 2004c).

### Standard 2

All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people (Kennedy, 2001; RCN, 2003a; DH, 2004c; WAG, 2004).

#### Supporting statement/rationale

- ◆ The acute hospital standards of the National Service Framework for Children, Young People and Maternity Services (DH, 2004c) and Kennedy (2001) reinforce the need for children and young people to be cared for by staff with the right knowledge, expertise and skills to meet their specific needs.

**Standard 3**

A minimum of two qualified (registered) children's nurses should be on duty 24 hours-a-day in all children's wards and departments.

**Supporting statement/rationale**

- ◆ In 1991, the Department of Health (1991) stated that a minimum of two registered children's nurses should be on duty 24-hours-a-day in all children's wards and departments.<sup>§</sup> However, in 2002 an RCN Paediatric Nurse Managers' Forum's Delphi study (RCN, 2002c) concluded that this minimum of two children's nurses is now insufficient to meet the clinical care needs of children and young people on a typical general children's ward.
- ◆ In order to optimise the standard of care given to children and young people, there should be sufficient staff available to give care directly and to ensure adequate supervision of care. Care should be of the appropriate high quality, safe, evidence-based, developed through awareness of clinical governance and delivered by staff with the correct knowledge and skills (DH, 2004c; WAG, 2004).

**Standard 4**

Each children's ward/department nursing establishment should have a minimum of 1 WTE (whole time equivalent) Band 7 and 2 WTE Band 6 qualified children's nurses (RCN, 2002c; RCN, 2003d).

**Supporting statement/rationale**

- ◆ These staffing levels will provide clinical leadership and supervision for junior staff, ensuring high quality care (RCN, 2009).

**Standard 5**

The minimum nurse/patient ratio should be as follows:

**Under two years of age** 1:3

**For other age ranges:**

During the day 1:4

During the night 1:5

(RCN, 2003e)

These registered children's nurse/patient baseline ratio's are reached by taking into account care requirements as determined by the child/young person's clinical need, age and level of development and will therefore alter dependent upon acuity and dependency.

**Supporting evidence/rationale**

- ◆ Optimal staffing levels and skill mix are required to ensure high standards of individualised nursing care of the child and support to the family, general safety, security and clinical governance. The nursing establishment outlined above is considered the minimum nurse staffing level (DH, 1991; Kennedy, 2001; RCN, 2003e; DH, 2004c).
- ◆ Ward nursing establishments need to be based on the level of clinical care each child/young person needs, as identified by a patient dependency tool (RCN, 1999; Auditor General [Scotland], 2002).
- ◆ The nursing establishment should also allow for a shift supervisor to coordinate the operational and clinical management of the ward or department and to include the delivery of care to a small caseload (RCN, 2003d; WAG, 2008).
- ◆ On a daily basis, the nurse staffing levels should reflect the dependency, acuity and complexity of care needs of the children/young people and their families in the ward/department at any given time (RCN, 2003d).
- ◆ If a children's ambulatory or assessment unit is adjacent to the ward area, the nursing establishment should be in addition to inpatient ward areas and separately identified for each area (RCN, 2003d).
- ◆ Additional nursing and play staff will sometimes be required depending on the number of occupied beds/cots on the ward/unit and the dependency/acuity of each child at any one time (NHSE, 1997, 1997a; PICS, 2001; RCN, 2001; DH, 2003a; WAG, 2004; National Association of Hospital Play Staff, 2006).
- ◆ Nurses undertaking paediatric intensive care (PIC) nursing should have completed an externally validated, knowledge, skill and competency based educational programme (equivalent to the ENB 415) (WAG, 2003).

<sup>§</sup> The figures stated relate to a ward/department operating on a 24hour/5-7 day basis

## 5.6 Nursing establishment and skill mix for neonatal services

### Standard 1

The nursing establishment for a neonatal unit should be based on the level of clinical care each baby requires. These have been defined as intensive care, high dependency care and special care, with a ratio of registered nurse\*\* to infants in each clinical category as follows:

Nurse/infant ratios:

Intensive care level	2-1:1
High dependency care level	1:2
Special care level	1:4

(BAPM, 2001;DH, 2003b; RCN, 2003e; DH, 2009a)

#### Neonatal levels of care

**Special care** is providing higher levels of clinical care including:

- the care of less immature premature babies who no longer need high dependency or intensive care whilst they grow to a stage of maturity ready for discharge. This includes tube feeding, maintenance of body temperature and monitoring
- the care of babies recovering from illnesses or operations e.g. treatment of infections, jaundice and special nutrition.

**High dependency care** is providing higher levels of clinical care, including those recovering from intensive care. This includes:

- ◆ babies receiving oxygen for immature lungs as they breathe on their own, sometimes assisted by higher pressure given via nasal prongs
- ◆ babies on intravenous nutrition or treated with chest drains or for convulsions, infections or metabolic problems.

**Short term intensive care** is provided for less immature babies who need mechanical assistance from a ventilator to breathe. Some babies may only need this for one to two days as the effect of artificial substances (surfactant) given through the breathing tube located in their lungs takes effect and they can move to high dependency care.

**Neonatal intensive care** is needed for babies born prematurely, simply to support organ systems until they have matured and for babies who are ill or who have congenital disorders.

(DH Report of the Neonatal Intensive Care Services Review Group, 2003b).

#### Supporting information/rationale:

- ◆ Optimal staffing levels and skill mix are required to ensure high clinical standards of individualised nursing care of mother and baby, general safety, security and clinical governance (RCN, 2001; DH, 2003b, 2009a).

## 5.7 Nursing establishment and skill mix in paediatric intensive care units (PICU) and high dependency units (HDU)

### Standard 1

The nursing establishment for children's intensive care and high dependency care should be based on the level of clinical care each child/young person requires. Levels of need have been defined as level 1 (lower) through to level 4 (highest), with a ratio of registered nurse to child/young person in each clinical category as follows:

#### Nurse/patient ratio:

Level 1	1:2 (equates to HDU)
Level 2	1:1
Level 3	1.5/2:1

(Some patients in Level 3 will require two nurses at the bedside over a 24 hour period)

Level 4	2-1
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(NHSE, 1997; Paediatric Intensive Care Society, 2001; RCN, 2003e).

\*\* Registered nurse: meaning RSCN /RN (Child) or Midwife

**Level 1: High Dependency Care, requiring nurse: patient ratio of 0.5:1**

Close monitoring and observation required, but child does not require acute mechanical ventilation. Examples include the child who is stable and awaiting transfer to a general ward; the child-undergoing close post-operative observation with ECG and pulse oximetry, receiving intravenous fluids or parenteral nutrition. Children requiring long-term chronic ventilation (with tracheostomy) are included in this category, as are children receiving short-term nasal CPAP.

**Level 2: Intensive Care, requiring nurse: patient ratio of 1:1**

The child requiring continuous nursing supervision, usually intubated and ventilated including endotracheal CPAP. Also includes the unstable non-intubated child, for example some cases with acute upper airway obstruction who may be receiving nebulised adrenaline, and the recently extubated child. The dependency of a Level 1 patient increases to Level 2 if the child is nursed in a cubicle.

**Level 3: Intensive Care, requiring nurse: patient ratio of 1.5:1**

The child requiring intensive supervision at all times, who needs additional complex therapeutic procedures and nursing. For example, unstable ventilated children on vasoactive drugs and inotropic support or with multiple organ failure. The dependency of a Level 2 patient increases to Level 3 if the child is nursed in a cubicle.

**Level 4: Intensive Care, requiring a nurse: patient ratio of 2:1**

Children requiring the most intensive interventions such as unstable or Level 3 patients managed in a cubicle; those on ECMO, and children undergoing renal replacement therapy

(Paediatric Intensive Care Society, 2001; WAG, 2003).

**5.8 Nursing establishment and skill mix in specialist children's wards/units****Standard 1**

In specialist wards or units where the treatment and care is concentrated around a disease group such as oncology, neurology, neurosurgery, cardiac surgery or renal units, the nursing establishment must reflect the type and acuity of care to be given to both child/young person and the family. The ratio of nurse to patient is likely to be higher and require a nurse/patient ratio of 1:3.

**Supporting evidence/rationale**

- ◆ Optimal staffing levels and skill mix are required to ensure high clinical standards and individualised nursing care of child/young person, general safety, security and clinical governance (DH, 1991; Kennedy, 2001; RCN, 2001; DH, 2004c).
- ◆ In children's oncology units, one third of patients will be classed as high dependency care, that is, requiring a nurse/patient ratio of 1:2. The remaining patients require a nurse/patient ratio of 1:3 (RCP, 1996; CCSG, 1997).
- ◆ The skills and competencies of the nursing team should reflect the ward's/unit's specialty. For example in children's oncology, 70% of the registered nurses should demonstrate their knowledge, skills and competence attained by specialist post registration education programme in children's oncology nursing (RCN, 2003e).
- ◆ Additional nursing and play staff will sometimes be required depending on the number of occupied beds/cots on the ward/unit and the dependency/acuity of each child at any one time (NHSE, 1997, 1997a; PICS, 2001; RCN, 2001; DH, 2003a; WAG, 2004; National Association of Hospital Play Staff, 2006).

**5.9 Nursing establishment and skill mix for accident and emergency (A&E) departments****Standard 1**

In a specialist children's unit/hospital with a dedicated paediatric A&E department, all nurses should be registered children's nurses, and a minimum of two nurses per shift should have recognisable post-registration trauma and emergency training, including advanced paediatric life support. These nurses will supervise care delivered to patients by other nurses and staff, student nurses and other non-registered staff.

### Supporting statement/rationale

- ◆ All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people (Kennedy, 2001; RCN, 2003a).
- ◆ The Intercollegiate Committee Report (RCPCH, 2007) and the Scottish Executive's Framework (2006a) support the standard of a minimum of one-registered children's nurse on each shift and a lead children's nurse to oversee the services provided for children and young people in A&E departments.
- ◆ Children's nurses in the A&E Department will be appropriately skilled and experienced in the care of children and young people in a trauma environment (RCPCH, 2007).
- ◆ The Department of Health stated that a registered children's nurse should be available 24 hours a day to advise on the nursing of children in other departments, such as accident and emergency and outpatient departments (DH, 1991).
- ◆ The acute hospital standard of the National Service Frameworks for Children, Young People and Maternity Services (DH, 2004c) and the Scottish Government (Scottish Executive, 2006a, 2007) reinforce the need for children and young people to be cared for by staff with the correct knowledge, expertise and skills to meet their needs. This includes staff who can provide Advanced Paediatric Life Support (APLS) or its equivalent.

### Standard 2

A senior children's nurse should be the lead children's nurse taking overarching responsibility for the development of policy and service planning for the care of children and young people in A&E departments.

### Supporting statement/rationale

- ◆ A lead senior children's nurse will be able to use their professional knowledge and experience to influence senior staff and managers. They will be able to communicate articulately and effectively with other trust senior managers and board-level directors on issues of importance for children and particularly so in relation to defining policy and overseeing practice for children and their families (RCN, 2004a; DH, 2004c).

### Standard 3

There should be a minimum of one registered children's nurse with trauma experience and advanced paediatric life support on duty at all times in general hospitals' A&E departments to assist, supervise, support and chaperone children, young people and their families.

### Supporting statement/rationale

- ◆ The NSF hospital standard states that A&E departments, surgical recovery areas, day care facilities, and on inpatient medical and surgical wards, there should be cover by staff who can provide Advanced Paediatric Life Support (APLS) or its equivalent, this is further supported by the Healthcare Commission (HCC, 2007).

### Standard 4

There should be a lead senior children's nurse in the A&E department at a general hospital, who takes overarching responsibility for the development of policy and service planning for children and young people and who liaises with the inpatient children's service.

### Supporting statement/rationale

- ◆ A lead senior children's nurse will be able to use their professional knowledge and experience to influence senior staff and managers. They will be able to communicate articulately and effectively with other trust senior managers and board-level directors on issues of importance for children and particularly so in relation to defining policy and overseeing practice for children and their families (RCN, 2004a; DH, 2004a).

## 5.10 Nursing establishment and skill mix for outpatient clinics

### Standard 1

There should be a *minimum* of one registered children's nurse on duty available to assist, supervise, support and chaperone children and young people in outpatient clinics (RCN, 2002).

### Supporting evidence/rationale

- ◆ Optimal staffing levels and skill mix are required to ensure high standards of individualised nursing care of the child/young person and support to the family, general safety, security and clinical governance. The above staffing level is considered the minimum nurse staffing level (DH, 1991, 2004c; Kennedy, 2001; RCN, 2001).

- ◆ The Department of Health (1991) stated that a minimum of one registered children's nurse should be on duty in outpatient clinics.
- ◆ The Department of Health stated that a registered children's nurse should be available 24 hours a-day to advise on the nursing of children in other departments, such as accident and emergency and outpatient departments (DH, 1991).
- ◆ All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people (Kennedy, 2001; DH, 2003a; RCN, 2003a; WAG, 2004a).
- ◆ Additional staff will usually be required, including health care support workers and play specialist; levels will always depend on the number and specialty of clinics operating and the number of patients attending each clinic (NHAPS, 2006; WAG, 2004).

### 5.11 Registered children's nurses available in operating departments

#### Standard 1

There should always be a minimum of one registered children's nurse on duty in the operating department, overseeing care of both the child/young person and the accompanying adult when children and young people are scheduled to have surgery.

#### Supporting evidence/rationale

- ◆ The acute hospital standard of the National Service Frameworks for children, Young people and Maternity Services (DH, 2003a) and the Scottish Executive (2007) reinforce the need for children and young people to be cared for by staff with the correct knowledge, expertise and skills to meet their needs.
- ◆ Some children may find going to theatre a daunting experience. The operating department should be as child-friendly as possible, and the child's parents/carers enabled to stay with them for as long as possible both before and after the operation (British Association of Paediatric Surgeons, 2002). An experienced children's nurse should always be available in the operating department to meet the needs of both child and accompanying adult.

- ◆ The RCN supports the encouragement of a parent or carer accompanying the child/young person into the anaesthetic room and recovery area having been appropriately prepared and supported by a registered children's nurse (RCN, 2004).

#### Standard 2

This children's nurse will be the lead nurse in the operating department for children and young people, and take the responsibility, with the theatre manager, for developing and endorsing policies and procedures that specifically meet the needs of this client group.

#### Supporting evidence/rationale

- ◆ The lead nurse will provide clinical leadership and supervision for junior staff, ensuring high quality care (RCN, 2009).

## SECTION 6: Educating the children's nursing workforce

### 6.1 Supporting students in practice settings

#### Standard 1

All learners undertaking pre-registration nursing and midwifery programmes have supernumerary status while on practice placements and until the final stages of their educational programme. This means that they are additional to the workforce requirement and staffing levels.

The NMC (2005) in its guidance for students of nursing and midwifery states:

“During your studentship, you will come into close contact with patients or clients. This may be through observing care being given, through helping in providing care and, later, through full participation in providing care. At all times, you should work only within your level of understanding and competence, and always under the appropriate supervision of a registered nurse or midwife, or a health professional with a registered nurse or midwife providing mentorship.”

(NMC, 2005)

### Supporting statement/rationale

- ◆ The learner is on placement to learn whilst practising under supervision, and not as a member of staff. However, they are expected to make an active contribution to the work in order for them to learn how to care for patients (RCN, 2007).
- ◆ The number of student nurses within any clinical environment should not exceed the number cited in the organisation's clinical placements educational audit, which should be updated annually (ENB, 2001, 2001a; UKCC, 1999; RCN, 2003e).
- ◆ Registered children's nurses also have the responsibility of mentoring, educating and supporting other groups of nurses, the largest group being student nurses from a number of different education/academic programmes. These students could be, for example, from the three main educational branches and from both diploma and degree levels, as well as others such as medical or physiotherapy students (RCN, 2007).

## 6.2 A children's nursing qualification

### Standard 1

- ◆ All nurses who provide care to children and young people should have a specific qualification in the nursing care of children and young people (RCN, 2003).

### Supporting evidence/rationale

- ◆ *The National Service Framework for Children, Young People and Maternity Services* (DH, 2004c), the Welsh Assembly Government (2004) and the Scottish Government (Scottish Executive, 2007) emphasise the need for children and young people to receive appropriate, high quality, evidence-based care, developed through clinical governance and delivered by staff with the correct knowledge and skills.
- ◆ The RCN recognises that children, young people, families and the public expect nurses, doctors and other professionals who are responsible for children and young people's health care to be appropriately qualified and experienced (Kennedy, 2001; RCN, 2003).
- ◆ Any nurse working with children without specific training, is working outside their registration status (RCN, 2003a). Non registered children's nurses must work alongside/under the supervision of a registered children's nurse when providing care to a child or young person.

- ◆ Regulatory requirements, government policy and guidance, from the 1959 Platt Report through to the more recent Kennedy and Carlile reports, all require that staff involved in the care of children and young people should have specific training to meet the special needs of this client group (Kennedy, 2001; Carlile, 2002; RCN, 2003a; WAG, 2004a, 2006; Scottish Executive, 2007).
- ◆ Nurses caring for children and young people need to be competent to do so. The term "competence" has been defined as: "the skills, knowledge, experience, attributes and behaviours required by an individual in order to perform a job effectively" (RCN, 2002a).
- ◆ The Royal College of Nursing's *Nursing education: a statement of principles* (RCN, 2002b) includes the principle that the initial preparation of nurses should be at degree level.

## 6.3 A community children's nursing (CCN) qualification

### Standard 1

Community children's nurses (CCNs) work with children and their families primarily in community settings (see also 3.5 above). Community children's nurses are registered children's nurses who have undertaken additional education and training.

### Supporting evidence/rationale

- ◆ All nurses who provide care to children and young people should have a specific qualification in the nursing care of children and young people (RCN, 2003a).
- ◆ A community children's nursing service is a cost-effective use of resources, reducing the need for hospital admissions or extended length of inpatient stay (see 3.1 and 3.5 above). (RCN 2008a, 2009).

## 6.4 Continuing professional development (CPD) and mandatory updating

### Standard 1

Each registered children's nurse must demonstrate achievement of formal, annual mandatory updating. This updating will be evidence-based, relevant to the level and area of the nurse's individual practice.

Mandatory training should include the following:

- ◆ Health, Safety and COSHH (Care of Substances Hazardous To Health)
- ◆ Fire prevention
- ◆ Moving and handling
- ◆ Food handling
- ◆ Paediatric Life Support (BLS, NLS, APLS)
- ◆ Safeguarding children (See section 6.5)
- ◆ Infection control
- ◆ Pain assessment (See Section 2.2).

(RCN, 2001a)

#### Supporting evidence/rationale

- ◆ This mandatory updating needs to be relevant to working with infants, children and or young people.
- ◆ The NSF (2003) Hospital Standard states that at every hospital location where care is provided to children there must be staff trained in basic life support for children. This training should be updated annually.
- ◆ Since amendment to pay scales and introduction of KSF outlines, there is now a clear emphasis on portfolio completion, lifelong learning, as well as regular personal development review (PDR) appraisal to monitor learning and competency in the workplace and to ensure that a competent confident workforce exists (WAG, 2004b).

#### Standard 2

Each registered children's nurse must demonstrate achievement of formal continuing professional development (CPD). CPD will be evidence-based, and relevant to the level and area of the nurse's individual practice. The organisation employing the nurse has a responsibility to support staff in their personal professional development.

#### Supporting information/rationale

- ◆ CPD is a requirement of continued registration with the Nursing and Midwifery Council (NMC). Evidence of a minimum of five CPD days (minimum of 35 hours) is required over the three-year period prior to re-registration. The NMC defines its PREP (CPD) Standard as any activity that maintains and develops professional competence, and this can be achieved in a variety of ways ([www.nmc-uk.org.uk](http://www.nmc-uk.org.uk), January 2008).
- ◆ Continuing professional development is a process of life-long learning for all individuals, to enable them to grow and develop as practitioners as well as to continue to adapt to meet the needs of children and families (RCN, 2001a).
- ◆ All staff should be trained and competent to undertake specific tasks and address specific care needs of patients and their families. They should also undertake CPD to maintain their competence and to stay abreast of scientific and technological advances (National Guideline Clearing House, 2006).
- ◆ Following qualification, nurses are required to demonstrate continuing professional development to ensure their fitness to practice competently. This includes the following:
  - ◆ when they move to a new area of practice, all nurses need a period of supervised practice
  - ◆ they must maintain their professional knowledge and competence. This includes mandatory updating (usually annually)
  - ◆ grasp opportunities to advance their skills, knowledge and expertise in leadership, research, and specialist and advanced nursing practice
  - ◆ participate in clinical supervision and reflective practice
  - ◆ engage different resources to keep abreast of nursing and professional issues e.g. journals, internet etc
  - ◆ participate in appraisal or individual performance review (IPR).

**Standard 3**

The performance and progress of nurses' development should be undertaken in a structured way through annual appraisal or individual performance review (IPR).

**Supporting information/rationale**

- ◆ Appraisal can address two principal professional issues: firstly, managing the nurse's performance against set objectives to measure levels of competence in the delivery of patient care; secondly, following on from this, providing support from the manager to promote and encourage the nurse's continuing professional development to achieve professional advancement.
- ◆ For NHS employees who come under the Agenda for Change agreement, individuals and their managers should use the NHS Key Skills Framework (KSF) outline for the post (foundation subset or full) as the basis of their discussion at their annual appraisal/review meetings (WAG, 2004b; [www.dh.gov.uk/agendaforchange](http://www.dh.gov.uk/agendaforchange)).

### **6.5 Levels of mandatory safeguarding children training, annually updated, for registered practitioners**

**Standard 1**

Training and education in safeguarding children is paramount for all staff working with children and young people. The training should be commensurate with the practitioner's role, responsibilities, level of skills and experience.

The NMC Code states:

- ◆ You must have the knowledge and skills for safe and effective practice when working without direct supervision.
- ◆ You must recognise and work within the limits of your competence.
- ◆ You must keep your knowledge and skills up to date throughout your working life.
- ◆ You must take part in appropriate learning and practice activities that maintain and develop your competence and performance.

(NMC, 2008)

**Supporting evidence/rationale**

- ◆ Training, at the appropriate level, should be mandatory for all nurses and health workers who may come into contact with children/young people, including ancillary and office staff (Laming, 2003; RCN, 2005; AWCP, 2008).
- ◆ Such training should be reflective of local multi-agency procedures (Laming, 2003, 2009).

## 4

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