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 health care standards to meet the needs of all children and young people. It promotes the commissioning of services specifically designed for children, advocating appropriate environments and nursing services across all health care settings (RCN, 2003). The RCN actively supports the principle that services should be developed based on the needs of children rather than professional and organisational roles and boundaries (Kennedy, 2010; DH, 2011; RCN, 2003, 2007).

The health care service standards within this document are based on issues arising from recent publications, including government policy and guidance (DH, 2010; 2013; 2013a), professional guidance from Royal Colleges and other bodies, national reports and inquiries and from the RCN’s own guidance documents (www.rcn.org.uk). Government documents include individual policy and guidance from the Welsh Assembly Government, the Northern Ireland Executive and the Scottish Government.

The standards outlined in this document apply across all four countries of the United Kingdom. The organisation of care may differ in the individual countries based on the national strategy for children’s services in each of these countries. However, the RCN promotes these standards as essential to ensure the highest standards of care and wellbeing for all infants, children, young people and their families in health care services wherever they are provided throughout the UK.

Note on terminology

When referring to neonates, children and young people in this document, the term ‘child’ or ‘children’ will be used to refer to anyone up to 18 years of age, unless explicit reference is made to specific age groups.
Health service standards for children and young people

The changing scene in children and young people’s health care

Since RCN health care service standards in caring for neonates, children and young people was last published by the RCN in 2011, there has been a greater focus on improved quality in health care provision and the views of users. The publication of the final report of the Francis Inquiry (Francis, 2013) emphasised the need to focus on quality and safety, with less emphasis on financial targets. The emphasis on putting patients at the heart of the NHS, providing compassionate care based on patient need and greater accountability for health care leaders, managers and professionals is having an impact on health care provision and regulation. In a climate where public finances are stretched, there is a push across the UK to ensure effective multi-agency and multi-professional working to avoid duplication, improve communication and provide effective care across the health care sector.

Health issues related to children and young people have been highlighted by governments across the UK. This may be due to the greater recognition that promoting good health from early in life may improve health outcomes in later life and to the fact that health outcomes for children in the UK have fallen behind that of other European countries. The Government’s pledge to give all children a healthy start in life (HM Government, 2010) has focused on the health of the child from conception to adulthood with greater significance attached to the early years, resulting in a planned increase in the number of public health nurses, such as health visitors and school nurses (DHSSPS, 2010; NHS England, 2013; Scottish Government, 2012).

The report of the Children and Young People’s Health Outcomes Forum (CYPHOF, 2012) focused strongly on the views of children, young people and their families. It highlighted the complex range of issues affecting child health and made recommendations for addressing these, which are now being addressed through government strategy and guidance (DH, 2013b). These issues are influencing how services are being planned, managed and delivered, with greater focus on local demographics and health care need through commissioning arrangements.

There is a continuing need for health care organisations to work in partnership with other bodies such as schools, local authorities, charities and private providers to address the demand on child health services. The increasing numbers, dependency and acuity of children in hospitals has led to an increased demand on children’s community services to provide care for children with acute problems closer to home (DH, 2011; Scottish Government, 2012a; DHSSPS, 2006). Such services are providing care in the home, at school and in voluntary and ambulatory care settings. The improved survival of children with congenital and acquired illness has increased the demand for complex care packages and extended the care requirements of children with life-limiting and life threatening illnesses. In addition, the increasing number of children with mental health needs has highlighted the need to focus on emotional wellbeing from an early age (HM Government, 2012). These groups of children are among the most vulnerable in our society. Good partnership working between all agencies and the child and family/carers can ensure that children receive the right care, from the appropriate professionals, at the right time.

The RCN service standards for the care of neonates, children and young people

A ‘standard’ is a level of quality against which other aspects can be measured. The RCN health care standards are presented under the following headings:

- working with children and their families using a multi-agency approach
- providing care close to home and preventing hospital admission where possible
- caring for children in an appropriate, safe environment
workforce planning and employment requirements
educating the children’s nursing workforce.

A quick-reference summary of all the standards is provided at the end of this publication.

Monitoring and auditing the standards

It is important to provide consistent and regular monitoring of the required standards to determine whether the standards are being achieved. Standards without measurement and monitoring make the standard-setting process a redundant activity. If the level of quality falls below the required standards, it is of concern; a monitored action plan will be required to ensure that the standards are reached and maintained.

Organisations can monitor the achievement and maintenance of standards through a number of quality processes, including:

- audit against key indicators/metrics
- audit against service standards using a regular cycle of audit
- external audit against professional guidance
- feedback from children and families through comment cards and user surveys
- staff surveys.

Commissioners will determine the frequency of some quality monitoring processes, depending on the requirements for evidence of service standards or improvement. However, the frequency of service audit is determined by the organisation. Where an audit provides results below the required standard, a monitored action plan is developed to highlight the action required to bring about sustained improvement and the people responsible for supervising and monitoring improvements.
Section 1: Working with children and their families using a multi-agency approach

The importance of the child, family and professionals working together

Standard 1
Services for children, young people and their families should be designed with a focus on the child at the centre of the services. Collaborative working between all health and social care professionals and agencies should ensure the highest standards of care for children and young people at all times.

Supporting evidence/rationale
- The National Service Framework for Children, Young People and Maternity Services (DH, 2004) describes children, young people and their families as partners in care. This is evident in the National Service Framework for Children, Young People and Maternity Services in Wales (WAG, 2005) and Scotland’s Getting it right for every child (Scottish Government, 2012a).
- Key principles of The NHS Constitution (DH, 2013, p3/4) are putting patients at the heart of service provision and working in partnership across organisational boundaries.
- Partnership with children and families underpins the principles of listening, providing information and choices outlined in the Department of Health’s response to Kennedy’s review of children’s services (DH, 2010; Kennedy, 2010). These principles have been incorporated into guidance relating to children for many years (DH, 1991) and are evident in the current planning framework from the NHS Commissioning Board (2013) for health care commissioners.
- Governments around the United Kingdom are actively promoting integrated services through care pathways across acute and community care, social services and other providers of children's health care (NHS England, 2013; Scottish Government, 2012a; Northern Ireland Executive, 2006; WAG, 2005). In Wales and Scotland new legislation is being progressed which further emphasises the importance of integrated services focused on the needs of children (Scottish Parliament, 2013; WAG, 2013).
- Professional bodies are working together to promote collaboration and integrated services within future government frameworks for child health and wellbeing (CYPHO, 2012; NHS Confederation, 2012; DH, 2013a). Organisations involved include health care providers, local authorities, representatives from patient groups and parents, charities, health care education providers and youth justice representatives (CYPHO, 2012; DH, 2013a).

Standard 2
Children, young people and their families should receive sufficient information, education and support through partnership working, to encourage a healthy lifestyle and to participate actively in decision making and all aspects of their care.

Supporting evidence/rationale
- Children and their families should be supported and appropriately informed where choices in health care are provided (Kennedy, 2010; NHS CB, 2013).
- Young people should be provided with support and information during transition to adult services, based on the needs of the individual (Kennedy, 2010). This should include choice relating to the timing of transition, especially for those children with long-term and complex needs (Scottish Executive, 2007; Northern Ireland Executive, 2006) and access to key workers (CYPHO, 2012).
including Article 12, which is the right for children's views to be heard (BACCH, 1995; Office of the Children’s Commissioner, 2013; Scottish Parliament, 2013; Scottish Government, 2013a; WAG, 2007; Northern Ireland Executive, 2006).

- Information provided should be age-appropriate and accessible to children and young people. Health care staff should be skilled in communicating with children of all ages and in promoting effective relationships with children and families (DH, 2010).

**Safeguarding children and young people**

**Standard 1**

All children have a right to protection from harm and adults have a responsibility to protect them at all times. In all organisations and environments providing services and support for children and young people, a culture promoting safety and physical and emotional wellbeing should be in place. This will ensure the needs of children are at the centre of their care and promote a focus on safeguarding.

**Supporting evidence/rationale**

- Infants, small children, and sick and vulnerable children are unable to meet their own basic needs, relying on adults to enable these needs to be met (DH, 2004; HM Government, 2013).

- A safeguarding culture requires robust systems and processes to be put into place with effective interagency working and the child at the centre of all services (Parliament, 2003; Laming, 2003, 2009; Munro, 2011; HM Government, 2013).

- Commissioners of health care services should ensure providers have effective systems and processes in place to meet the duties required under Section 11 of the Children Act 2004 (Parliament, 2004; CQC, 2009; HM Government, 2013).

- All health care providers must have systems, policies and procedures in place to support health care professionals in safeguarding children effectively. These systems should reflect national and local LSCB and equivalent guidance (AWCPPRG, 2008; RCPCH, 2010; Munro, 2011; HM Government, 2013).

- Policies and procedures for safeguarding children should be in place and available organisation-wide (RCN, 2014a; Laming, 2009; HM Government, 2013).

- Policies should include how to raise concerns about work colleagues, procedures to follow where staff are accused of abuse, and how to refer to the Disclosure and Barring Service (HM Government, 2013; RCN, 2013a).

- A ‘designated’ or ‘named’ nurse and doctor for children's safeguarding should be appointed, with a clearly defined role and sufficient time to fulfil the commitments of the role. (RCN, 2014b; RCPCH, 2014; Scottish Government, 2012a; Smith et al, 2012; HM Government, 2013). The contact details for these professionals should be available to all employees throughout an organisation (RCN, 2014b; RCPCH, 2014).

- In order to ensure effective communication, information-sharing processes should be in place covering communication both within and outside an organisation (DHSSPS, 2003, 2008a; HM Government, 2008, 2013; Scottish Government, 2010, 2013; RCN, 2013b).

- A single, integrated child health record, including access to records from all previous reviews and treatment by professionals, should be in place (Laming, 2003; RCN, 2014b; Kennedy, 2010; RCPCH, 2014).


**Standard 2**

All nurses who come into contact with children as part of their work should undertake initial training and annual updating in children's safeguarding. This training must be relevant to their role and level of responsibility.

**Supporting evidence/rationale**

- Training in safeguarding should be included in all pre-registration nursing and midwifery programmes (RCN, 2014b; NMC, 2010; RCPCH, 2014).

- All nurses working with children should have the basic competences relating to safeguarding children and young people (RCN, 2012, 2014b; RCPCH, 2014; Scottish Government, 2013).
Supporting evidence/rationale

- The transition of care from children's to adult services requires specific attention as adolescents have different needs from children and adults (DH, 2004; Kennedy, 2010; Scottish Government, 2009; Coleman, 2011).
- Transition should be a seamless process, requiring careful planning by all services and professionals involved (RCN, 2013d; CYPHOF, 2012; Scottish Government, 2012a).
- All staff involved in the care of young people should be trained in transition and the specific needs of young people, and have the skills to communicate, engage and understand the needs of this age group (DH, 2010a, 2011a).
- A named key worker should be appointed to oversee the process and facilitate communication between all services and the young person (WAG, 2005; DH, 2008, 2011a).
- A shared protocol should be in place, owned and adopted by both children's and adult services (RCN, 2013d; DH, 2008, 2010; RCPE, 2008; CYPHOF, 2012).
- Effective transition can improve health-related quality of life for young people with complex needs and disabilities (DH, 2008, 2010a; CYPHOF, 2012).
- Transition should be flexible, based on the needs of the young person, and may take longer for those young people with complex or multiple health needs (WAG, 2005; RCN, 2013e).
- The young person and family should always be involved in transition planning to ensure they remain actively engaged in decisions regarding their care (RCN, 2013e; RCPE, 2008; DH, 2008; CYPHOF, 2012; Scottish Government, 2012a).
- Due to medical improvements there are an increasing number of young people with uncommon conditions surviving into adulthood. The development of adult services to meet the needs of these young people has not always met demand. This has resulted in some services extending their age range – for example, cancer services (NICE, 2005). Some services have extended their provision, such as adult congenital heart disease services (ACHD) (NHS England, 2013a). However, there is still a gap in adult health care provision for some conditions (Kennedy, 2010; CYPHOF, 2012).
- Clear policies on transition and a pathways of care will enable health professionals, young people and...
their families to understand where they are in the transition pathway (RCN, 2013e; CYPHOF, 2012). Opportunities for review of the pathway are beneficial to support understanding and provide opportunities for adjustment (RCN, 2013d).

- Audit of pathways will enable these to be amended to ensure the most effective pathway is in place (RCN, 2013e).

**Standard 2**
Transition to adult services should take place once young people have the skills to function in an adult service.

**Supporting evidence/rationale**
- The Royal College of Paediatrics and Child Health (2003) believe that young people’s care should not transfer completely to adult services until they are able to function in that service.

**Access to a qualified school nurse**

**Standard 1**
Transitions occur at many times during a child’s life (RCN, 2013d; Scottish Government, 2012a), presenting the risk that children with health needs may be lost from services if transitions are not well managed. When a child with health needs starts school, pathways for transition from health visiting to school nursing services enable efficient, seamless support to continue (DHSSPS, 2010; DH, 2013d).

**Supporting evidence/rationale**
- Partnership working between professionals promotes seamless services and promotes health and wellbeing in young children (DH, 2013d).
- Early intervention has a positive impact on outcomes for the child (Munro, 2011).
- The school nurse is often the first point of access to health care services for school age children (Carlile, 2012).
- The development of the public health nursing role aims to provide greater integration between school nurses and health visitors (DHSSPS, 2010).

**Standard 2**
All school age children should have access to a qualified school nurse. The role and responsibilities of the school nurse should be clearly defined, reflecting the geographical, social and health context in which they work.

**Supporting evidence/rationale**
- School nurses provide an important link between children and young people and other health services, promoting health and wellbeing and management of health needs (Scottish Government, 2011; DH, 2012; RCN, 2012a)
- School nurses will have a greater role in supporting children who are carers, helping to reduce truancy, improve mental health and wellbeing, and ensure support is available at home (DH, 2013c).
- School nurses influence the general health of children and the healthiness of schools (DHSSPS, 2010; RCN, 2012a)
- School nurses provide access to a trusted, impartial professional who is able to provide confidential advice regarding health issues which are relevant to young people (DH, 2012a).

**Standard 3**
The school nurse’s remit and responsibilities should be based on local need and national priorities and will include:
- safeguarding
- provision of ‘drop in’ clinics, advice and signposting
- health promotion activities, including the healthy child programme
- health screening
- immunisation
- sex education
- personal, social and health education
- education of teaching staff
- interventions with children with long-term health problems and complex needs
- running specialist clinics, eg smoking cessation, nutrition and exercise, and sexual health advice
- counselling and mental health issues
- support for young carers (RCN, 2014a).
Supporting evidence/rationale

- School nurses deliver many of the outcomes for children outlined in the following guidance:
  - National Service Framework for Children, Young People and Maternity Services (DH, 2004);
  - National Service Framework for Children, Young People and Maternity Services in Wales (WAG, 2005);
  - Our Children and Young People – Our Pledge (DHSSPS, 2006);
  - Our Children and Young People – Our Pledge: Action Plan 2008-2011 (DHSSPS, 2008);
  - Delivering a Healthy Future: An Action Framework for Children and Young People’s Health in Scotland (Scottish Executive, 2007);
  - Healthy Lives, Healthy People: our strategy for public health in England (HM Government, 2010);
  - A guide to getting it right for every child (Scottish Government, 2012a);
  - Working Together to Safeguard Children (HM Government, 2013);
  - Giving all children a healthy start in life (HM Government, 2013a).


Child and adolescent mental health (CAMHS) services

Standard 1
All health care providers for children and young people will ensure staff have the knowledge and skills required to assess and meet the wellbeing and mental health needs of children and young people. This includes having arrangements in place for timely access to appropriate services including CAMHS assessment, psychiatry, talking therapies, social work and CAMHS nurses.

Supporting evidence and rationale

- National governments recognise the importance of promoting wellbeing from birth and through early childhood, as a driver to reducing poor mental and physical health later in life (DH, 2010a, 2012b; DHSSPS, 2012; Parliament, 2013; Scottish Government, 2012b, 2013a; WAG, 2010, 2010a).
- Children’s services focus on children’s emotional or psychological wellbeing as well as their physical health from birth and throughout childhood, with the aim of reducing mental health problems and poor outcomes in childhood and later life (DH, 2012b; Scottish Government, 2013b; Western Health and Social Care Trust, 2011).
- CAMHS services promote the mental health and wellbeing of all children from birth through to adulthood through high quality, multidisciplinary and multi-agency child and family-centred networks (DH, 2008a; NICE, 2008, 2009, 2011, 2012; Galloway, 2012; Western Health and Social Care Trust, 2011).
- All staff working with children, whatever the care setting, are appropriately trained to assess and meet the emotional and mental health needs of children across all age groups, including neonates. All staff clearly understand their roles and responsibilities and maintain competence to achieve these (DH, 2008a; RCN, 2012, 2013c; RCP, 2013).

Standard 2
Children’s hospitals and children’s units of two or more wards should have a lead nurse for children and young people’s mental health and wellbeing. This nurse will have completed relevant training and have sufficient knowledge and skills to undertake a lead role with children with mental health needs. They will also support their colleagues in managing the care of these children.

Supporting evidence and rationale

- Hospital services have effective arrangements in place to access CAMHS assessment and services for children admitted to acute beds. This includes access to child psychiatry services to advise and manage conditions where the child or young person is at risk of taking their own life (DH, 2010a).
- All nurses working with children in acute settings have the knowledge and skills to assess children’s emotional and mental health, and know how to make a referral to CAMHS services (DH, 2010a).
- Children and young people with mental health problems can have high dependency needs. This should be considered as part of the overall dependency on the ward, with care provided by nurses with the relevant knowledge and skills (RCN, 2013c).
Section 2: Providing care closer to home and preventing hospital admission where possible

Admission of children and young people to hospital

Standard 1
Children and young people should only be admitted to hospital when appropriate care cannot be provided in the community. If admission to hospital is required, facilities should be available for a parent or carer to stay with the child and discharge should be planned once care can be provided at home (Platt, 1959; DH, 1991; AfSC, 2013).

Supporting evidence and rationale
• Successful networks of care, including specialist children’s hospitals, promote good outcomes, with care provided as close to home as possible. A single point of access to the network via general practice would ensure access to the most appropriate part of the network (Kennedy, 2010; CYPHOF, 2012a; AfSC, 2013).
• Agreed care pathways outlining the roles of all providers across the network, including hospitals, community services, education, social care and the voluntary sector, will promote integrated care across the local network (CYPHOF, 2012; DH, 2011, 2013b; Dunhill, 2013).
• Admission of a child to hospital can be stressful for both the child and family. This stress can be reduced and the psychological outcome of admission improved by providing family-centred care, including good communication with parents and involving children in activities such as school (Commodari, 2010).
• When children are admitted for day case procedures, care should reflect the recommendations of government and professional bodies (RCN, 2013f).

Standard 2
Children admitted for surgery should be admitted to a day case unit where possible, with ongoing care and support provided at home by the community children’s nursing team.

Supporting evidence and rationale
• All nurses involved in day case surgery should be familiar with and understand local, government and professional guidance and recommendations (RCN, 2013f).
• Pre-admission clinics staffed by play specialists and nurses provide pre-operative assessment and preparation of the child and family (RCN, 2013f; RCSE, 2013).
• All staff must be able to initiate resuscitation and staff trained in advanced paediatric life support (or equivalent) must be available (RCN, 2013f; RCSE, 2013).
• Registered children’s nurses with the relevant knowledge and skills must be available to provide care to children both in hospital and following discharge home (RCN, 2013c, 2013e).

The recognition and assessment of acute pain in children

Standard 1
All nurses caring for children, whatever the location of care, should be competent in the assessment of pain in both verbal and non-verbal children, using a reliable, valid pain assessment tool appropriate to the child’s age and stage of development. Nurses should be able to administer appropriate analgesia and use non-pharmacological interventions to reduce or eliminate pain.

Supporting evidence and rationale
• Where pain goes unrecognised in children, it can become severe and difficult to control, can delay recovery, lead to physical deterioration and have a negative and long-lasting psychological impact (RCN, 2009; Twycross et al, 2009).
• Pain management policies and guidance, including assessment procedures, should be used to promote effective pain relief (RCSE, 2013).
Pain should be anticipated in infants and children undergoing a variety of investigations and procedures (RCN, 2009).

Where children cannot report pain, the level of pain can be underestimated, making it essential to involve families and use an assessment tool appropriate for the individual child (APAGBI, 2012).

The child and family should be prepared in the use of pain tools and the family should be involved in assessment of a child’s pain, encouraging the child to self-report pain where possible (APAGBI, 2012).

Procedural pain can be managed using a combination of medication and non-pharmaceutical strategies (Twycross et al, 2009; APAGBI, 2012; WHO, 2012).

Standard 2
Registered children’s nurses should be available to provide pain relief to children once an assessment has been completed. This may involve administration of analgesia using medical prescription, patient group directives (PGD), or prescription by a qualified nurse prescriber; use of non-pharmaceutical interventions; or a combination of strategies.

Supporting evidence and rationale
- Good communication is central to the process of gaining consent to any procedure, using the principle: “no decision about me without me” (NHS CB, 2012, p12).
- The NMC requires nurses to gain consent for all care and treatment, respecting a patient’s right to be involved in all decisions (NMC, 2008, 2013).
- The consent process involves more than gaining a signature on a form. It involves assessment of the child’s capacity to understand and make decisions about procedures, the provision of information verbally and in writing, and checking that the child and family fully understand the procedures. Consent is only obtained once this process is complete and the child and family have agreed to treatment. Consent can be obtained verbally but surgical procedures require written consent (DHSSPS, 2003a; DH, 2009; Scottish Executive, 2006; WAG, 2009).
- Children and young people should be directed to reliable information regarding treatment and access to information about the performance of the hospital. This might be provided through NHS Choices, support group websites and CQC (www.cqc.org.uk; www.nhs.uk).
- Gaining consent from children under 16 years of age can be complex and requires adherence to national and local guidance (www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/consent/). Professionals involved in the consent process must understand ‘competence’ to consent in relation to age, stage of development and cognitive understanding. This applies to children under the age of 16 years and between 16 and 18 years of age, when guidance in Scotland differs from the rest of the UK (DHSSPS, 2003a; DH, 2009; Scottish Executive, 2006; WAG, 2009).

Consent

Standard 1
Children and their families should be involved in decision making about all aspects of their care and treatment. Consent should be gained for all procedures and examinations following provision of full and age-appropriate information. The opportunity should be provided for the child and family to discuss the treatment, including all risks and side effects.

Supporting evidence and rationale
- As children are often not able to describe their pain, it is easy to underestimate the severity of the pain (Twycross et al, 2009).
- Administration of pain relief should not be delayed when a child is found to be in pain and assessment should be ongoing to determine the efficacy of the pain relief used (RCN, 2009).

Standard 2
Consent policies should clearly outline the action to be taken where there is a difference of opinion between a competent young person and their parent(s), or when a parent refuses to consent to life saving treatment for their child.

Supporting evidence and rationale
- All nurses involved in treating children must understand the law, national and local guidance relating to consent in the country in which they

- All patients have the right to withhold or withdraw consent at any time (DHSSPS, 2003a; DH, 2009; Scottish Executive, 2006; WAG, 2009).

- Children and young people should be provided with clear information regarding their rights on consent and given the opportunity to discuss this (DH, 2001; NHS Scotland, 2006; Gormley-Fleming and Campbell, 2011).

### Nursing children in community settings

#### Standard 1

All children and young people should have access to qualified community children’s nurses when they require care at home or in community settings close to home.

#### Supporting evidence and rationale

- Children’s health care needs should be met at home or in the local community, unless treatment can only be provided in hospital (Scottish Government, 2013b).

- Community children’s nurses are essential to the success of care pathways which reduce the amount of time children spend in hospital (Barnes et al, 2013; DH, 2011; Harding et al, 2012).

- Community children’s nursing teams should provide care for children with acute, long term and complex care needs, as well as those requiring end of life care, to facilitate early discharge for those children who can be cared for at home with intermittent nursing support (Carter and Coad, 2009; DH, 2011).

- Community children’s nursing services can provide quicker access to treatment for children seen by GPs and provide a lower-cost option for commissioners of child health (Barnes et al, 2013).

- Providing nursing care at home is important to children and their families, because the family is able to function in a normal environment with support. Parents report greater partnership working and involvement in decision making, while children value being able to sleep in their bed and having familiar things around them (Carter and Coad, 2009).

- Community children’s nursing services enable children with life-limiting and life-threatening illness to die at home with their family (DH, 2011).

- In Wales, children’s community nurses are being integrated into wider child health teams following the recognition that community children’s nurses are key to the health and wellbeing of children in Wales (Harding et al, 2012).

### Access to specialist palliative nursing care

#### Standard 1

Children and young people with a life-threatening or life-limiting illness (and their families) have the right to have the highest professional standard of individually focused care in all care settings. This should be provided from the point of diagnosis or recognition, through their life, at the end of life and into bereavement.

“In 2010, there were more than 40,000 children between 0 and 19 years of age with life limiting conditions in England. There has been a year-on-year increase in the preceding 10 years, due to improved technology and treatments.”

(Fraser et al, 2012)

#### Supporting evidence and rationale

- The aim of palliative care is to provide holistic care for the child and family from the point of diagnosis, addressing physical, emotional, spiritual and social needs to enhance the quality of life for the child and family (TFSL, 2013).

- Community children’s nurses should be actively involved in the care of children requiring palliative care (DH, 2011; McNamara, 2011).

- Due to the need to provide palliative care in diverse settings such as hospitals, hospices and the child's home, a wide range of nurses require palliative care skills (WAG, 2008; RCN, 2012; Scottish Government, 2012c; DHSSPS, 2014).

- All children should have equitable access to palliative care services based on their individual needs. A palliative care network can address issues relating to equity of service provision to ensure that end of life services are available for all children.
requiring them (NICE, 2005; Scottish Government, 2012c).

- Depending on the child’s underlying illness or condition, the care pathway is often a complex one, it can exist over a significant period of time, and be associated with complex care needs (TfSL, 2013).

- It is important for commissioners and care providers to understand the varied health, social and education needs of this group of children. Therefore services must be commissioned to be flexible and meet the wide range of needs of this group (TfSL, 2013).

### Standard 2

Children’s nurses providing palliative care across all care settings require the knowledge and skills required to care for children with life-limiting conditions. Education programmes should conform to national standards for education and practice for nurses working in this specialty.

### Supporting evidence and rationale

- The Royal College of Nursing (2012b) competence framework outlines the knowledge, skills and performance levels required by palliative care nurses. The framework provides competences for all levels of nurses from health care support workers to advanced practice nurses undertaking research and service development. These levels are linked to the knowledge and skills framework.

- The charity Together for Short Lives has produced best practice guidance for end of life care. The guidance stresses the importance of communication, advanced care planning, symptom control and care after death. It also provides guidance on staff support and supervision (TfSL, 2013).

- Clinical commissioning groups should ensure provision of universal, targeted and specialist palliative care services in order to commission a comprehensive service capable of meeting all the needs of these children, including pain and symptom relief (TfSL, 2013).

- Hospices are an essential element of the provision of palliative care, as are bereavement services following diagnosis of a life-limiting or life-threatening illness (TfSL, 2013).

- National guidance recommends that all professionals involved in the provision of palliative care should have access to specialist education and training in order to develop appropriate knowledge and skills (Scottish Government, 2012c; WAG, 2008).

- The DHSSPS (2014) review of palliative and end of life care in Northern Ireland refers to the need to develop interdisciplinary education using the three levels of care outlined by the European Association for Palliative Care taskforce (www.eapcnet.eu).

- The Together for Short Lives’ standards framework (McNamara, 2011) provides a guidance for palliative care across the age range from neonates to adults, which include checklists to measure delivery against these standards.
Section 3: Caring for children in an appropriate, safe environment

Children should not be nursed in adult environments

Standard 1
Children and young people should be cared for in environments designed to meet their needs.

Supporting evidence and rationale
- The principle that children should not be nursed in adult wards has long been recognised (Platt, 1959; DH, 1991, 2003; Kennedy, 2001; WAG, 2003; DHSSPS, 2004; Scottish Executive, 2007). However, in some parts of the UK, a significant number of children under 16 years of age are cared for in adult settings (RQIA, 2012).
- Where services are provided in areas for children and adults, such as A&E and theatres, children should have separate waiting facilities and treatment areas (RCSE, 2013; RCPCH, 2012; RCN, 2014c).
- Young people over the age of 16 should be cared for in adolescent facilities (RCPCH, 2003; Viner, 2007; Coleman, 2011). Where these are not available the young people should be provided with separate accommodation on a children’s ward, ensuring staff have the appropriate knowledge and skills to provide high standards of care for this age group (Viner, 2007; DH, 2011a).

Standard 2
Services for children should be provided in appropriately designed environments. This should include areas for play, education, parents, and young people.

Supporting evidence and rationale
- Services should be designed to meet the specific needs of children and young people (DH, 2004; NHS Estates, 2004; Viner, 2007; Kennedy, 2010; Coleman, 2011).
- Provision should be made for young people to have suitable relaxation areas and space for visitors (DH, 2011a).
- Health care services for children should be provided in buildings that are accessible, safe, designed specifically for children in order that they are child and family-friendly and “respect children’s right to dignity, privacy, family support and self-control” (NHS Estates, 2004a).
- Children, young people and their parents should be involved in the design of new health care facilities for this age group (NHS Estates, 2004a).

Standard 3
Where children undergo investigation and treatment in areas with adults, advice should be available from a senior children’s nurse and registered children’s nurses should be available to provide direct care.

Supporting evidence and rationale
- A senior children’s nurse should be available throughout the 24 hour period to provide support and advice regarding care. Registered children’s nurses should be employed to provide care for children, with the expertise of adult nurses provided where required (RCN, 2013c).
- A senior children’s nurse will be responsible for providing advice and support throughout the organisation, wherever children and young people are cared for. This responsibility will include ensuring governance arrangements take account of the needs of children (RCN, 2013c).
- Children should be cared for by professionals who have the knowledge, skills and expertise to meet the needs of this age group (RCN, 2013c).

A separate area in operating department reception and recovery

Standard 1
Children and young people undergoing surgery should be cared for in an environment that is suitable to their age and level of development.
Supporting evidence and rationale

- The definition of the upper age limit of a child varies across the UK. It is 13 years for surgical services in Northern Ireland and 16 years in the remainder of the UK (RCSE, 2007; Scottish Government, 2009; DHSSPS, 2010a; WAG, 2010b).
- Children should be operated on either in a dedicated children's surgical session or at a time that meets the needs of the child and carer (RCSE, 2013).
- Where mixed lists are in progress, children should be cared for in a separate recovery area, by nurses with the appropriate knowledge and skills to manage children (RCSE, 2013).
- The environment should meet the needs of children and young people across the age range (DHSSPS, 2010a; RCSE, 2013).
- Children's surgery should be provided as part of a network of surgical services (Scottish Government, 2009; DHSSPS, 2010a; WAG, 2010b; RCSE, 2013).

Standard 2
Parents should be supported in accompanying the child to theatre and into the anaesthetic room and given access to support their child in the recovery area.

Supporting evidence and rationale

- A parent or carer should be encouraged to accompany the child/young person into the anaesthetic room until they are asleep. Parents should be invited into recovery to support their child as he or she wakes and returns to the ward (WAG, 2010b; RCSE, 2013).
- Where mixed adult and children's day care units are operating, separate areas must be provided for children and their families, ideally with separate lists (RCSE, 2013).

The use of single rooms or cubicles in children’s wards

Standard 1
A policy should outline the priorities for use of single rooms or cubicles, to ensure that these facilities are used effectively for children with a clinical need to be separated from the ward area.

Supporting evidence and rationale

- A bed management policy will include guidance on allocating single rooms based on clinical need. This will be overseen by a senior nurse responsible for bed allocation (DH, 2010b).
- The infection control policy will underpin the effective use of single rooms for those children who must be isolated to prevent the spread of infection or those who require protection from infection. This will contribute to the control of infections (DH, 2010b).
- Single rooms might also be allocated when a child has high dependency needs or to a young person on a ward with much younger patients (NHS Estates, 2004).
- Single rooms should have bathroom facilities to assist with control of infection (NHS Estates, 2004a).
- An organisation should calculate the number of single rooms required to effectively isolate those who need isolation (DH, 2010b).

Caring for adolescents

(See also: Transitional care – moving children from children’s services to adult health care teams on page 7).

Standard 1
An area designed specifically for the needs of adolescents and young people should be available to ensure an appropriate environment and private space to receive visitors. Ideally this will be a unit designated for adolescents and young adults, but it may be a designated area on a children's ward or adult service, which caters for their developmental, social and health needs.

Supporting evidence and rationale

- Young people have distinct needs from those of children and adults (CYPHO, 2012; RCN, 2013g). A survey by Viner (2007) reported adolescent preference for dedicated adolescent facilities. These should be provided for in adolescent inpatient wards or as a designated adolescent facility on a children's ward (Viner, 2007).
- Young people should be involved in the design of health services for their age group (WHO, 2008; NHS Confederation, 2012; RCN, 2013d).
There should be joint training for a range of professionals in paediatrics and care of young adults, and all staff caring for adolescents should have received appropriate training to meet the needs of this age group (Kennedy, 2010; Coleman, 2011). Online training modules are available through the RCPCH adolescent health programme (www.rcpch.ac.uk).

Hospital youth workers can help reduce the difficulties encountered by young people when admitted to hospital, such as social isolation, stigma attached to illness and loss of independence. Youth workers can promote peer support and increased confidence as well as better relationships with family and staff, and provide support with transition to adult services (Hilton and Jepson, 2012).

**Standard 2**
Health services for young people should be accessible in places frequented by young people and should be clearly signposted.

**Supporting evidence and rationale**
- Health information for young people should be available in a variety of formats aimed specifically at this group, in order to get them engaged in health (DH, 2011a). Examples of national and local youth-focused information can be found at: www.youngminds.org.uk/for_children_young_people, www.getthelowdown.co.uk/, and https://kentsexualhealth.nhs.uk/for-young-people.
- School nurses play a key role in the provision of information and health services to young people (see also page 8: Access to a qualified school nurse).

**Valuing the involvement of parents and carers in their child’s care**

**Standard 1**
Children and young people have a right to have a parent or carer with them at all times if they wish. This includes parents/carers being accommodated close to their child overnight.

**Supporting evidence and rationale**
- Suitable accommodation should be provided for family members which affords them privacy, dignity, security and independence (RCN, 2003).
- Breastfeeding mothers and their infants should be given special consideration, including access to a quiet breastfeeding room, a nutritious diet and adequate fluids. A breastfeeding specialist should be available for support as required (unicef.org.uk).
- Distress caused by admission to hospital should be minimised for children and their families through the provision of child and family-friendly facilities and services (RCN, 2003). Children should be discharged and cared for in the community/at home as soon as their condition allows, to reduce distress for the child (Carter and Coad, 2009).

**Standard 2**
Children’s nurses should work in partnership with families to enable parents and carers to participate in care when they wish to. Regular communication with children and parents will enable the nurse to listen to parents’ views and input, and to work in partnership. Information from parents and agreements about involvement in care should be documented so that all team members are aware of current parental involvement in care.

**Supporting evidence and rationale**
- Negotiation, collaboration and good communication are all key nursing skills used to develop good partnership working with children, parents and carers (Kelly, 2007; Lee, 2007).
- Good partnership working can reduce stress in the child and family, increasing the confidence of parents in their child’s care and improving the child’s wellbeing while in hospital. In addition, effective partnership working can improve job satisfaction for nurses (Lee, 2007).
- Good partnership is based on helping the parent or carer understand their child’s condition in order to gain confidence in care required and recognising them as experts in their child (Lee, 2007).
- The UN Convention on the Rights of the Child (1989) states that children have the right to be involved in decisions about their care. To do this, children must be given information they can understand as well as choices, which will vary.
depending on the age of the child (DH, 2001; NHS Scotland, 2006).

- The NHS does not routinely seek the views of children and young people, who were represented in less than one per cent of surveys between 2001 and 2011 (Hargreaves and Viner, 2012).

**Nursing documentation and record keeping**

**Standard 1**
It is important to maintain a high standard of record keeping at all times to ensure the effective assessment, delivery and evaluation of patient care. The standard of documentation is integral to the overall provision of care to the child.

**Supporting evidence and rationale**
- Good record keeping is central to nursing practice, “it is not an optional extra to be fitted in if circumstances allow” (NMC, 2010a).
- Nurses should adhere to “relevant legislation, case law and national and local policies” regarding the content and standards for records, regardless of whether they are written, electronic or in other formats (NMC, 2010a p7).
- Nurses should adhere to the Data Protection Act 1998 and be familiar with guidance relating to the Act provided by the Information Commissioner’s Office (Parliament, 1998; http://ico.org.uk/).
- Nurses have a professional responsibility to ensure that health care records provide a complete and accurate account of care planning and evaluation, treatment provided, risks associated with treatment, changes to care and information communicated to the child and family. It should provide other professionals involved in the child’s care with a clear picture of care and treatment given and required (NMC, 2010a).
- Nurses must adhere to local policies for the use of electronic records, including not sharing passwords or allowing unauthorised access by leaving the computer open (NMC, 2010a).
- Accountability for electronic or written records is the responsibility of the person signing the record. Where records are written the signature should be clear, with the name and designation of the nurse printed alongside. Any abbreviations should be understood by the child and family receiving the care (NMC, 2010a).

**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 education as their condition allows.

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**Good record keeping**, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses, such as:
- helping to improve accountability
- showing how decisions related to patient care were made
- supporting the delivery of services
- supporting effective clinical judgements and decisions
- supporting patient care and communications
- making continuity of care easier
- providing documentary evidence of services delivered
- promoting better communication and sharing of information between members of the multi-professional health care team
- helping to identify risks, and enabling early detection of complications
- supporting clinical audit, research, allocation of resources and performance planning
- helping to address complaints or legal processes.

(NMC, 2010a, p3)
Supporting evidence and rationale

- Local authorities are responsible for ensuring provision of education to all school-age children who are unable to attend mainstream school for health reasons (DfE, 2013).
- Hospital services should reflect the specific and individual needs of children which includes the need to continue with their education through access to a hospital school (RCN, 2003). This may involve provision of facilities to sit exams.
- There is evidence that parents/carers experience reduced stress as a result of the provision of education to children in hospital, making parents better able to support their child (Commodari, 2010).

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

Standard 1
A key responsibility of nurses caring for children is to provide a safe environment for children, young people and their families in hospitals and community settings, where possible.

Supporting evidence and rationale

- The NMC Code (2008, p5) states that, “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 (Laming, 2009).
- When children are in hospital, the organisation has a responsibility to ensure that the environment is safe, fit for purpose and does not pose a risk to children or their families (CQC, 2010).

A safe and secure environment

Standard 1
Providing children and young people with a safe and secure environment is essential at all times. This includes the physical environment, the staff working within it, and the systems and processes that support staff and protect patients and the public.
Supporting evidence and rationale

- Hospitals must have systems and processes in place to ensure that the environment is safe for children using and visiting the services. This includes outside spaces designated for children (DH, 2004a; CQC, 2010).
- Policies, procedures and risk assessments should be in place to ensure the security of children, monitoring entrances to departments and preventing unauthorised access (CQC, 2010). This is usually controlled using CCTV with swipe cards or digital locks.
- Staff should wear their name badge clearly displaying their organisation and full name, with a recent photograph as identification. Staff should challenge colleagues not wearing an appropriate name badge.

Using medical devices and health care products safely

Standard 1
All nurses caring for children should be knowledgeable about the safe use and management of medical devices and health care products used within their clinical area. Nurses should not use medical devices or equipment for which they have not received training. This includes agency and bank nurses.

Supporting evidence and rationale

- Policies and procedures and equipment manuals should be available to nurses using medical devices in the care of children (MHRA, 2014; CQC, 2010).
- Nurses must be trained in the safe use of medical devices, have undergone competency assessment, including interpreting information provided and acting promptly in the event of equipment error.
- Annual updates must be completed where equipment is modified or updated (MHRA, 2014).
- Accurate training records must be completed and retained by the nurse and manager to promote patient safety and monitor training (MHRA, 2014; CQC, 2010).

Standard 2
All medical equipment should be the correct size and specification for use of children. Its design must be tailored to meet the different needs of children across the age range.

Supporting evidence and rationale

- The equipment must be safe and fit for purpose, appropriate for the age and size of the infant, child or young person (CQC, 2010).
Section 4: Workforce planning and employment requirements

Detailed information regarding staffing levels and workforce planning can be found in *Defining staffing levels for children and young people’s services* (RCN, 2013c). The document is available at: www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf

Recruitment and selection of all staff working with children and young people, to ensure patient safety

Standard 1
All staff employed to work with children and young people should only be allowed to commence employment following a thorough and complete recruitment process.

Supporting evidence and rationale
- All applicants for posts within the NHS should comply with the NHS employment checks standards. This includes staff on fixed term and permanent contracts, volunteers, students/trainees, contractors, temporary staff such as locums, agency and trust bank staff. NHS employers must monitor recruitment practice of external organisations that provide services, such as cleaners and waste contractors (www.nhsemployers.org).
- Recruitment checks will cover six areas: identity, right to work, professional registration and qualifications, employment history and references, criminal record and barring checks, and work health assessment (www.nhsemployers.org).
- Criminal record checks are obtained through different organisations across the UK. These are the Disclosure and Barring Service (England and Wales) (www.gov.uk/disclosure-and-barring-service), Disclosure Scotland (www.disclosurescotland.co.uk) and Access NI (Northern Ireland) (www.nidirect.gov.uk/access-ni).

The NHS employment check standards must be used for all people employed to work in the NHS. These standards are grouped into six areas with guidance on each:
- identity
- right to work
- professional registration and qualifications
- employment history and references
- criminal record and barring checks
- work health assessment.
Further information about each of these standards can be found at www.nhsemployers.org

Organisations must have safe, robust recruitment policies and procedures in place. This might include checklists for staff undertaking recruitment, to ensure all relevant checks are made on those members of staff working with children (CQC, 2010). This will include staff working in temporary roles such as students and volunteers.

All requests for references should be made to a company’s human resources department, which provide written/electronic confirmation of dates of employment. However, this information might not provide sufficient detail to determine whether the person has the knowledge and experience required. Therefore, additional written information from the previous line manager may be sought (NHS Employers, 2013).

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 services for children and young people in each local
health care organisation (such as a health board or trust). This individual will be able to speak knowledgeably, confidently and credibly about the needs of children and young people in the area in order to influence decision makers and service provision.

Supporting evidence and rationale

- All health care 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, 2013c).
- There is a strong commitment at present to putting clinical staff at the forefront of planning services within the NHS, both at a local and national level, based on the needs of the local population. Input from experienced clinical staff is essential to these two commissioning processes (WAG, 2010c; NHS CB, 2011; RCN, 2011a).
- Nurses will play an important role in designing and developing health services for the future (Scottish Executive, 2006b).
- 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 a local level (RCN, 2003).
- Senior children's nurses will be knowledgeable about care required by children and ensure that children receive the care they need (RCN, 2014d).

Standard 2

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 (RCN, 2013c).

Supporting evidence and rationale

- The senior nurse will be involved in decisions regarding the design and provision of services for children, wherever children's services are provided throughout an organisation (RCN, 2013c).

Standard 3

Each organisation should follow an accepted, objective and rational formula for staffing and skill mix in all environments where services are provided for children. This formula should be used in conjunction with professional judgement of senior children's nurses to determine the specialty specific nurse-to-patient ratios required to deliver safe, effective and high quality care.

Supporting evidence and rationale

- Ensure appropriate staffing levels and skill mix to optimise the standard of care children and young people receive, regardless of time or location, and provide equity of service provision across the UK (DHSSPS, 2004; Scottish Executive, 2007; RCN, 2013c).
- Children and young people should receive appropriate, high quality, evidence-based care, developed through sound clinical governance frameworks and delivered by staff with the right knowledge and skills (CYPHOF, 2012; RCN, 2013c).
- The Francis Inquiry recommended that boards must consider nurse staffing levels and consult nurse directors where changes to nurse staffing and skill mix is proposed, to ensure that the impact on the quality of care provided is considered (Francis, 2013).
Workforce tools are available for use in a variety of settings (www.workforceplanning.scot.nhs.uk). Further information about tools designed for use in children’s services is detailed in Defining staffing levels for children and young people’s services (RCN, 2013c).

There is increasing evidence that higher standards of care are provided where there are higher ratios of nurses to patients (Rafferty et al, 2007; Kane et al, 2007; Aiken et al, 2008).

Care by staff who have received the training required to meet the needs of the client group undoubtedly influences the quality of care received (Francis, 2013).

Changes in dependency and acuity will affect the number of nurses required. Recent increases in the dependency and level of acuity of children in hospital, combined with a reduction in lengths of stay, increases the level of acute conditions in children cared for in the community. These issues require regular review of workforce and skill mix requirements across all services (RCN, 2013c).

Professional judgement, based on experience and knowledge of local services, should be used alongside other tools to determine workforce requirements (RCN, 2013b). For more information on Nursing and Midwifery Workforce Planning Tools go to: www.workforceplanning.scot.nhs.uk

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 be qualified in the nursing care of children and young people.

Supporting evidence and rationale

- Children, young people, families and the public can expect nurses and other professionals caring for children to have the appropriate qualifications, knowledge and skills (RCN, 2014d).
- Multiple reports over the years have recommended that staff involved in the care of children should have the training and knowledge to meet the needs of children (Platt, 1959; DH, 1991; Kennedy, 2001; CYHO, 2012).
- The NMC (2008) states that nurses must have the knowledge and skills required for safe and effective practice when working without direct supervision and must work within the limits of their competence. Nurses working with children without specific training are deemed to be working outside their registration and should work under the supervision of a children’s nurse when providing care to young children (RCN, 2007).

Standard 2
All nurses working with children and young people should have the following knowledge, skills and competence.

Core knowledge, skills and competence required to care for infants, children and young people

- An understanding of children's rights and the role of the family in health care settings.
- An understanding of the legislation and local guidance affecting the health care setting in which care is provided.
- Effective communication with children, including use of strategies appropriate to age and development, involving children and families in decision making and facilitating children to contribute to their own health care.
- The ability to work in partnership with families to plan nursing care and agree the level of input parents and carers are able to provide, supporting them in the care of their child.
- Assessment of clinical needs, based on physiological signs, physical and emotional development and information provided by parents/carers, in order to identify physical, mental health or social problems and detect signs of deterioration.
- Assessment and interventions required to deal with pain in children, including use of appropriate pain assessment tools.
- Administration of analgesia, anti-emetics and other medication by all routes, including the use of associated equipment, based on locally agreed protocols.
- Basic and advanced paediatric life support (or equivalent) skills.
- Recognition of signs and symptoms of neglect or abuse.
abuse and knowledge of local safeguarding systems to ensure that appropriate referrals are made to promote the safety of the child.

- Assessment of fluid balance and management, and administration of intravenous infusions and associated equipment.
- Managing care in consultation with the wider multidisciplinary team and communicating all necessary information to the appropriate professionals.

(AAGBI, 2002; RCN, 2007; RCPCH, 2010, 2012; DH, 2013b)

**Supporting evidence and rationale**

- Children and young people are developing physically and mentally and change rapidly throughout childhood and adolescence. This period requires care which is significantly different from adult care and should be provided by those who have received education and training in their specific needs (DHSSPS, 2004, 2010; DH, 2012, 2013a, 2013b; Scottish Executive, 2007; Scottish Government, 2012a; WAG, 2005).
- There are variations in policy across the countries of the UK. Therefore, nurses must be clear about the policies applicable to their local services (DHSSPS, 2004, 2010; DH, 2012, 2013a, 2013b; Scottish Executive, 2007; Scottish Government, 2012a; WAG, 2005).
- The NMC (2008) requires nurses to recognise and work within the limits of their competence and undertake professional development to maintain and develop knowledge and skills. Nurses who have not undertaken training related to children, but provide care to children, may be working outside the limits of their competence.

**Nursing establishment and skill mix**

**Standard 1**
The RCN (2013c) has outlined core minimum staffing and skill mix standards to be applied in services providing care to children (see Appendix A table on page 36).

**Supporting evidence and rationale**

- Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring care (RCN, 2013c).
- Workforce plans should be reviewed annually to ensure that demographic and activity changes are reflected in the services provided (RCN, 2010, 2013c).

**Standard 2**
There must be a senior member of staff to supervise the nursing team and co-ordinate care and communication with other members of the multidisciplinary team.

**Supporting evidence and rationale**

- A supervisory ward sister should be available to supervise work on the ward, for families to discuss care and concerns, and to other professionals such as doctors conducting a ward round or liaison health visitors (RCN, 2009a, 2011a, 2013c).
- In addition to the ward sister, a competent, experienced Band 6 nurse is required throughout the 24 hour period to offer support to the nursing team. This will provide an experienced children’s nurse to advise on clinical issues relating to children across an organisation (RCN, 2013c).

**Standard 3**
The minimum ratio of registered nurses to patients should be 1:3 for children under two years of age and 1:4 for children over two years. These ratios are reached by taking into account children’s clinical needs, age and stage of development. These factors will determine the dependency and acuity required by each patient, and may alter over time.

**Supporting evidence and rationale**

- Medical advances and shorter lengths of stay in hospital have increased the intensity of workload across all settings throughout the 24 hour period (RCN, 2013c).
- On a daily basis, nurse staffing levels should reflect the dependency, acuity and complexity of care needs of children and their families, regardless of setting, at any given time (RCN, 2013c).
- Where children’s ambulatory or day care services are attached to a ward, these areas should be staffed separately with registered children’s nurses to ensure that children in both areas receive high standards of care (RCN, 2013c).
Nursing establishment and skill mix for specialist services

Where dependency and acuity are high, and where very specialist services are provided, higher ratios of nurses to patients will be required. Examples include infants and children requiring high dependency or intensive care and those children who have undergone major surgery or are receiving complex chemotherapy (RCN, 2013c). Detailed guidance on staffing children’s general and specialist services can be found at: www.rcn.org.uk/publications

Standard 1

Nurse staffing and skill mix within neonatal services must reflect the level of care and interventions provided and the number of cots available. Units can provide a mix of services from special care to high dependency and intensive care, which requires the following ratios of nurses to infants:

- **Nurse: infant ratio**
  - 1:4 Special care
  - 1:2 High dependency care
  - 1:1 Intensive care (some babies requiring complex treatments may require 2:1)

(DH, 2009a; BAPM, 2010).

**Supporting evidence and rationale**

- Optimal staffing levels and skill mix are required to ensure high clinical standards of individualised nursing care for infants and mothers as well as maintaining safety, governance processes and security (DH, 2009a; RCN, 2013c).
- There is increasing evidence that both the number of nurses and the knowledge and skills of nurses in neonatal units have an impact on outcome (BAPM, 2010).
- Seventy per cent of nurses working in a neonatal unit should hold a recognised neonatal nursing qualification (DH, 2009a; BAPM, 2010; RCN, 2013c).
- The Scottish Neonatal Nurses’ Group outlined the competence and skills required at four levels of practice, based on Benner’s novice to expert taxonomy, which takes nurses from newly qualified nurse to experienced manager, educator/researcher or advanced practitioner (Greig et al, 2006). These competences have since been updated and developed into UK-wide guidance for development of competence in neonatal nursing (RCN, 2011b; BAPM, 2012).

Standard 2

The nursing establishment for children’s intensive care and high dependency must reflect the level of care and interventions provided and the number of cots available. Units can provide a mix of services from high dependency care to basic and advanced levels of intensive care, requiring the following ratios of nurses to children:

- **Nurse: child ratio**
  - 1:2 Level 1 (high dependency)
  - 1:1 Level 2
  - 1.5:1 Level 3
  - 2:1 Level 4

This ratio will rise to the next level where children are nursed in a cubicle (PICS, 2010; RCN, 2013c).

**Supporting evidence and rationale**

- The PICS standards (2010) provide clear information for calculating nursing numbers based on bed numbers in children’s high dependency and intensive care.
- Where the PICU provides an integrated retrieval/transport service, the retrieval nurses must not be factored into the bedside nursing establishment, to ensure that high standards of care are provided to all children (RCN, 2013c).
- Where high dependency beds are provided in a district general hospital or in specialist wards in a children’s hospital, the establishment and skill mix must take into account the higher levels of care, knowledge and skills required to ensure all children on the ward receive high standards of care (RCN, 2013c).
- All nurses working with children requiring high dependency nursing should have a children’s high dependency qualification, with senior nurses having training and experience in children’s intensive care (RCN, 2013c).
**Standard 3**

Children’s specialist services often provide treatment and care for children with specific groups of disorders, such as congenital cardiac disease, neurology or oncology. In these services, the nursing establishment must reflect the level of care and interventions provided, the number of cots or beds available and services provided to children outside the hospital setting.

**Supporting evidence and rationale**

- It is estimated that around one third of the children on specialist wards will require high dependency care (RCN, 2013c), necessitating a ratio of nurses to patients of 1:2 or 1:1 if high dependency is provided in a cubicle. In areas such as oncology, a nurse-to-patient ratio of 1:3 is required for all other children (RCN, 2013c).

- Optimal staffing levels and skill mix are required to ensure high clinical standards of individualised nursing care for children and families, as well as maintaining safety, governance processes and security. This may require additional nurses and play staff at times of high demand (RCN, 2013c).

- The knowledge and skills required by nurses should reflect the service specialty, with 70 per cent of nurses having completed an educational programme and competence assessment in the specialty (RCN, 2013c).

- A practice educator is required to oversee the continuing education of the nursing staff to ensure nursing knowledge and skills meet the needs of the children (RCN, 2011c, 2013c).

- At least one nurse with specialty training should be on shift throughout the 24 hour period (RCN, 2013c).

- Where specialist services are provided as part of a network, nursing roles should be clearly defined, with a lead nurse for the network (RCN, 2011c).

- Workforce planning should consider the specific multidisciplinary requirements of specialist services (Scottish Executive, 2006c; Scottish Government, 2009).

- The workforce of the future will need a higher level of skill and knowledge and will require more collaborative working between professionals and services (DHSSPS, 2004).

**Core skills required in ambulatory care settings**

- Paediatric life support – a basic life support course with yearly update (PILS/EPLS course) will be suitable for nurses working in outpatients, but in all other ambulatory care settings at least one nurse should be trained in APLS/EPLS.

- Safeguarding children to level 3, as defined by the intercollegiate framework.

- Effective communication with children and parents.

- Pain assessment and management.

- Recognition of the sick child. (RCPCH, 2010, 2012; RCN, 2013c)

- A registered children’s nurse is required to support, chaperone and assist children and families in outpatient departments (RCN, 2013c).

- A minimum of two registered children’s nurses are required at all times in children’s assessment units and day surgery services. One nurse should have
advanced resuscitation skills. Where nurse-led services are provided, a minimum of one advanced nurse practitioner is required throughout opening times (RCN, 2013c).

- Where children are seen in mixed adult and children’s minor injuries and day care units, all staff should have training in the core skills required to care for children. Ideally, children’s nurses will be employed to provide direct care, but clear policies should be in place to access advice from a senior children’s nurse within the organisation (DH, 1991; RCPCH, 2002; RCN, 2013c).

- Children attending ambulatory care settings should have access to play specialists and facilities in all settings to help reduce anxiety and support them during treatment (RCN, 2013c).

**Standard 5**

Operating departments where children are treated should employ nurses with the appropriate skills and competences to support surgeons and anaesthetists in the care of children. These nurses will ideally be registered children’s nurses.

**Supporting evidence and rationale**

- There should always be one registered children’s nurse in theatre when children are scheduled for surgery, to oversee care and support children and families (DH, 2003, 2004).

- As a minimum, theatre nurses and operating department assistants must possess basic airway and circulatory management skills in children (DHSSPS, 2010a; RCA, 2010, 2013; RCN, 2013c; RCSE, 2013).

- One children’s nurse should be available in recovery areas where children are recovering following anaesthetic (RCA, 2010, 2013; RCN, 2013c).

- In addition to the training required in ambulatory care, theatre nurses are required to have additional skills and competences in the management of children (see box below).

- A children’s surgical service should have an identified lead nurse, who is responsible for policies and procedures and for monitoring use of these (RCSE, 2013).

### Additional competences required by nurses in operating departments

- Assessment of physiological observations.
- Advanced paediatric life support skills.
- Assessment of fluid balance and management and administration of intravenous fluids.
- Administration of analgesia, anti-emetics and other drugs by all routes and use of the associated equipment.

(AAGBI, 2002; RCN, 2013c)

**Standard 6**

Children and young people should have access to appropriately qualified nurses to support health care needs throughout their lifespan. This includes health visitors, school nurses and community children’s nurses (CCN), as well as support staff such as health care assistants and play workers.

**Supporting evidence and rationale**

- A CCN service requires nurses with a range of skills in order to provide a comprehensive service (DH, 2011). This will include nurses with specialist skills such as oncology, palliative care and epilepsy, as well as nurses with acute care skills and skills in the management of children with complex needs and learning disabilities (Harding et al, 2012; Dunhill, 2013; RCN, 2013c).

- For a child population of 50,000, a minimum of 20 WTE CCNs are required to provide for children with acute and complex needs as well as long-term illnesses and end of life care (RCN, 2013c).

- There is currently no clear guidance on the optimum caseload for a health visitor, although it is thought to be somewhere between 250 and 400 children, depending on deprivation index and the number of vulnerable families (RCN, 2013c).

- A minimum of one school nurse is required for each secondary school and its local primary schools. School nurses will be supported by nursery nurses and health care assistants.
Section 5: Educating the children’s nursing workforce

A children’s nursing qualification

Standard 1
All nurses who provide care to children and young people should hold a relevant qualification in children’s nursing.

Supporting evidence and rationale
- The RCN recognises that children, young people and their families expect health care professionals who are responsible for children and young people’s health care to be appropriately qualified and experienced (Kennedy, 2001; CYPHOF, 2012; RCN, 2007a, 2012).
- Children and young people should receive appropriate, high quality, evidence-based care, delivered through robust clinical governance frameworks by staff with the appropriate knowledge and skills (WAG, 2005; RQIA, 2012; Scottish Government, 2012; DH, 2013a, 2013b).
- Nurses without a children’s nursing qualification should work under the supervision of a children’s nurse, unless they have been provided with relevant training and competence assessment or risk working outside their level of competence (RCN, 2007).
- There is increasing recognition of the importance of having the appropriate knowledge and skills to meet the health care needs of children (Platt, 1959; DH, 1991; Kennedy, 2001; CYPHOF, 2012).
- The NMC defines competence as “the combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective nursing practice and interventions”. http://standards.nmc-uk.org
- Pre-registration children’s nursing education has mirrored the changes in health care provision, with many programmes now preparing nurses to work across all settings including the community (RCN, 2013c). Post-registration training is often based on local programmes of theoretical education, practice supervision and competence assessment.

Supporting students in practice settings

Standard 1
All learners undertaking pre-registration nursing programmes have supernumerary status whilst in practice placements to support them to become proficient. This means that they are additional to the nursing workforce (NMC, 2004).

Supporting evidence and rationale
- Student nurses must make an active contribution to the care of children to enable them to develop the skills required to become competent children’s nurses. They will be supported by a mentor and practice teacher to ensure that they practice under supervision until they achieve competence in specific skills (NMC, 2004).
- The number of students placed in one area should not exceed that agreed with the university, to ensure that students are provided with sufficient learning opportunities to develop their skills. These numbers should be reviewed annually, based on an education audit (NMC, 2008a).

Continuing professional development and mandatory updates

Standard 1
All registered children’s nurses must undertake statutory and mandatory update training in accordance with the policies and guidance of their employer. This guidance will be evidence-based and relevant to the area of practice.

Supporting evidence and rationale
- Statutory training is the training employers must provide by law or where the government or regulators require employers to provide training based on legislation. These include health and safety, fire and equalities training (SFH, 2012).
Mandatory training is the training which the employer determines individual groups require in order to effectively and safely fulfil their role. This may include new national policy or local guidance (SfH, 2012).

Training frequency and method of delivery will be determined by the employer and should be monitored by managers and employees to ensure completion within stated timescales.

Subjects for inclusion in the UK wide framework include (SfH 2012):
- conflict resolution
- equality, diversity and human rights
- fire safety
- health, safety and wellbeing
- infection prevention and control
- moving and handling
- resuscitation
- safeguarding children and adults
- information governance (England and Scotland)
- violence and aggression (Wales).

Additional topics relevant to children are:
- paediatric resuscitation (basic to advanced)
- pain assessment and management
- recognition of the sick child
- communicating with children and families.

The KSF provides a structure for professional development and learning associated with appraisal and objective setting, which encourages a process of lifelong learning (RCN, 2012, www.nhsemployers.org).

Employers have a responsibility to support nurses in their professional development, in order to develop practice for children using the services.

Following qualification, and each time a nurse moves to a new area, they must demonstrate their competence through a period of supervised practice which will include:
- undertaking statutory and mandatory training required in the clinical area
- participating in clinical supervision and reflective practice
- using a competence assessment framework to record achievements
- using a variety of resources to develop knowledge, such as e-learning and journals
- participating in appraisal and objective setting
- identifying opportunities to extend knowledge and skills in the areas of practice, education, management or research.

**Standard 2**

All registered children's nurses must undertake continuous professional development relevant to the area in which the individual nurse works.

**Supporting evidence and rationale**
- The NMC (2008) requires nurses to take part in learning and development activities which will help maintain and develop competence and practice. These activities must take a minimum of 35 hours in three years, and must be recorded and reflected on.

The KSF enables practitioners to develop knowledge and skills in a structured way using a combination of learning methods, contributing to their continuous professional development (RCN, 2012, www.nhsemployers.org).

**Standard 3**

The performance and progress of a nurse's development should be undertaken through regular appraisal and objective setting.

**Supporting evidence and rationale**
- Appraisal should recognise the achievements of the individual and identify how they have contributed to service/organisational objectives (www.nhsemployers.org).

Appraisal both assesses the individual performance against agreed objectives and can facilitate discussion around future development and career pathway. Therefore, preparation for appraisal is essential to achieve the greatest benefit for the individual being reviewed (www.nhsemployers.org).

The KSF provides structure to the appraisal process and can provide a focus for discussion of future development.
Levels of mandatory safeguarding training for registered practitioners

**Standard 1**
Training and education in safeguarding children is essential for every person working with children and young people. The level of training should be commensurate with the role of the individual.

**Supporting evidence and rationale**
- *Intercollegiate guidance on safeguarding* (RCPCH, 2014) describes six levels of training with guidance on the type of role applicable for each level. All clinical staff working directly with children and young people must undertake mandatory Level 3 training to ensure sufficient knowledge and skills to recognise children at risk and report concerns appropriately.

- All children’s safeguarding training should reflect the content of local multi-agency safeguarding procedures (Laming, 2003, 2009).

- Nurses have a responsibility to ensure that training has been completed and they understand local safeguarding policies and guidance on reporting concerns.
The RCN health care service standards in caring for neonates, children and young people: a summary

### Working with children and their families using a multi-agency approach

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Services for children, young people and their families should be designed with a focus on the child at the centre of the services. Collaborative working between all health and social care professionals and agencies should ensure the highest standards of care for children and young people at all times.</td>
</tr>
<tr>
<td>2</td>
<td>Children, young people and their families should receive sufficient information, education and support through partnership working, to encourage a healthy lifestyle and to participate actively in decision making and all aspects of their care.</td>
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#### Safeguarding children and young people

<table>
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<tr>
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<tbody>
<tr>
<td>1</td>
<td>All children have a right to protection from harm and adults have a responsibility to protect them at all times. In all organisations and environments providing services and support for children and young people, a culture promoting safety and physical and emotional wellbeing should be in place. This will ensure the needs of children are at the centre of their care and promote a focus on safeguarding.</td>
</tr>
<tr>
<td>2</td>
<td>All nurses who come into contact with children as part of their work should undertake initial training and annual updating in children’s safeguarding. This training must be relevant to their role and level of responsibility.</td>
</tr>
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#### Transitional care – moving children from children's services to adult health care teams

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Transition to adult services is a process which requires planning and collaborative working between the young person and their family, children’s or adolescent services, and adult services. All health care services should have an agreed policy regarding transition, which is shared by all relevant services, and a care pathway which outlines the possible pathways between adult and children’s services.</td>
</tr>
<tr>
<td>2</td>
<td>Transition to adult services should take place once young people have the skills to function in an adult service.</td>
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#### Access to a qualified school nurse

<table>
<thead>
<tr>
<th>Standard</th>
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<tbody>
<tr>
<td>1</td>
<td>Transitions occur at many times during a child’s life (RCN, 2013d; Scottish Government, 2012a), presenting the risk that children with health needs may be lost from services if transitions are not well managed. Pathways for transition from health visiting to school nursing services enable efficient, seamless support to continue as a child with health needs starts school.</td>
</tr>
<tr>
<td>2</td>
<td>All school age children should have access to a qualified school nurse. The role and responsibilities of the school nurse should be clearly defined, reflecting the geographical, social and health context in which they work.</td>
</tr>
<tr>
<td>3</td>
<td>The school nurse’s remit and responsibilities should be based on local need and national priorities and will include:</td>
</tr>
</tbody>
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- safeguarding
- provision of ‘drop in’ clinics, advice and signposting
- health promotion activities, including the healthy child programme
- health screening
- immunisation
- sex education
- personal, social and health education
- education of teaching staff
- interventions with children with long-term health problems and complex needs
- running specialist clinics eg smoking cessation, nutrition and exercise, and sexual health advice
- counselling and mental health issues
- support for young carers.
# Working with children and their families using a multi-agency approach (continued)

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

**Standard 1**  All health care providers for children and young people will ensure staff have the knowledge and skills required to assess and meet the wellbeing and mental health needs of children and young people. This includes having arrangements in place for timely access to appropriate services including CAMHS assessment, psychiatry, talking therapies, social work and CAMHS nurses.

**Standard 2**  Children's hospitals and children's units of two or more wards should have a lead nurse for children and young people's mental health and wellbeing. This nurse will have completed relevant training and have sufficient knowledge and skills to undertake a lead role with children with mental health needs and to support their colleagues in managing the care of these children.

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# Providing care closer to home and preventing hospital admission where possible

### Admission of children and young people to hospital

**Standard 1**  Children and young people should only be admitted to hospital when appropriate care cannot be provided in the community. If admission to hospital is required, facilities should be available for a parent or carer to stay with the child and discharge should be planned once care can be provided at home.

**Standard 2**  Children admitted for surgery should be admitted to a day case unit where possible, with ongoing care and support provided at home by the community children's nursing team.

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

**Standard 1**  All nurses caring for children, whatever the location of care, should be competent in the assessment of pain in both verbal and non-verbal children, using a reliable, valid pain assessment tool appropriate to the child's age and stage of development. Nurses should be able to administer appropriate analgesia and use non-pharmaceutical interventions to reduce or eliminate pain.

**Standard 2**  Registered children's nurses should be available to provide pain relief to children once an assessment has been completed. This may involve administration of analgesia using medical prescription, patient group directives (PGD), or prescription by a qualified nurse prescriber, use of non-pharmaceutical interventions or a combination of strategies.

### Consent

**Standard 1**  Children and their families should be involved in decision making about all aspects of their care and treatment. Consent should be gained for all procedures and examinations following provision of full and age-appropriate information. The opportunity should be provided for the child and family to discuss the treatment, including all risks and side effects.

**Standard 2**  Consent policies should clearly outline the action to be taken where there is a difference of opinion between a competent young person and their parent(s), or when a parent refuses to consent to life-saving treatment for their child.

### Nursing children in community settings

**Standard 1**  All children and young people should have access to qualified community children's nurses when they require care at home or in community settings close to home.

### Access to specialist palliative nursing care

**Standard 1**  Children and young people with a life-threatening or life-limiting illness (and their families) have the right to have the highest professional standard of individually focused care in all care settings. This should be provided from the point of diagnosis or recognition, through their life, at the end of life and into bereavement.

**Standard 2**  Children's nurses providing palliative care across all care settings require the knowledge and skills required to care for children with life-limiting conditions. Education programmes should conform to national standards for education and practice for nurses working in this specialty.
### Caring for children in an appropriate, safe environment

<table>
<thead>
<tr>
<th>Standard 1</th>
<th>Standard 2</th>
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<tbody>
<tr>
<td><strong>Children should not be nursed in adult environments</strong></td>
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<tr>
<td>Children and young people should be cared for in environments designed to meet their needs.</td>
<td>Services for children should be provided in appropriately designed environments. This should include areas for play, education, parents and young people.</td>
</tr>
<tr>
<td><strong>Standard 3</strong></td>
<td></td>
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<tr>
<td>Where children undergo investigation and treatment in areas with adults, advice should be available from a senior children's nurse, and registered children's nurses should be available to provide direct care.</td>
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| **A separate area in operating department reception and recovery** |  |
| Children and young people undergoing surgery should be cared for in an environment that is suitable to their age and level of development. | Parents should be supported in accompanying the child to theatre and into the anaesthetic room and given access to support their child in the recovery area. |

| **The use of single rooms or cubicles in children's wards** |  |
| A policy should outline the priorities for use of single rooms or cubicles, to ensure that these facilities are used effectively for children with a clinical need to be separated from the ward area. |  |

| **Caring for adolescents** |  |
| An area designed specifically for the needs of adolescents and young people should be available to ensure an appropriate environment and private space to receive visitors. Ideally this will be a unit designated for adolescents and young adults, but it may be a designated area on a children's ward or adult service, which caters for their developmental, social and health needs. | Health services for young people should be accessible in places frequented by young people and should be clearly signposted. |

| **Valuing the involvement of parents and carers in their child's care** |  |
| Children and young people have a right to have a parent or carer with them at all times if they wish. This includes parents/carers being accommodated close to their child overnight. | Children's nurses should work in partnership with families to enable parents and carers to participate in care when they wish to. Regular communication with children and parents will enable the nurse to listen to parents' views and input, and to work in partnership. Information from parents and agreements about involvement in care should be documented so that all team members are aware of current parental involvement in care. |

| **Nursing documentation and record keeping** |  |
| It is important to maintain a high standard of record keeping at all times to ensure the effective assessment, delivery and evaluation of patient care. The standard of documentation is integral to the overall provision of care to the child. |  |

| **Meeting educational needs of children and young people in hospital** |  |
| During admission to hospital, children and young people should be able to continue with their education as their condition allows. |  |

| **The importance of play in health care settings** |  |
| All children should have access to play and relaxation facilities, overseen by qualified health play specialists and play leaders. |  |

| **Managing risks in environments where children and young people are cared for** |  |
| A key responsibility of nurses caring for children is to provide a safe environment for children, young people and their families in hospitals and community settings, where possible. |  |

| **A safe and secure environment** |  |
| Providing children and young people with a safe and secure environment is essential at all times. This includes the physical environment, the staff working within it, and the systems and processes that support staff and protect patients and the public. |  |

| **Using medical devices and health care products safely** |  |
| All nurses caring for children should be knowledgeable about the safe use and management of medical devices and health care products used within their clinical area. Nurses should not use medical devices or equipment for which they have not received training. This includes agency and bank nurses. | All medical equipment should be the correct size and specification for use with children. Its design must be tailored to meet the different needs of children across the age range. |
### Workforce planning and employment requirements

<table>
<thead>
<tr>
<th><strong>Recruitment and selection of all staff working with children and young people, to ensure patient safety</strong></th>
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<tbody>
<tr>
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<table>
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<tr>
<th><strong>A knowledgeable and experienced senior nurse to oversee and develop services for children and young people locally</strong></th>
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<th><strong>Developing a staffing and skill mix formula that is accepted nationally and internationally</strong></th>
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<th><strong>Knowledge, skills and competence of nurses working with children and young people</strong></th>
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<th><strong>Nursing establishment and skill mix for specialist services</strong></th>
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<table>
<thead>
<tr>
<th><strong>Nursing establishment and skill mix by relevant professional bodies</strong></th>
</tr>
</thead>
</table>
| **Standard 1** | Nurse staffing and skill mix within neonatal services must reflect the level of care and interventions provided and the number of cots available. Units can provide a mix of services from special care to high dependency and intensive care, which requires the following ratios of nurses to infants:  
  * **Nurse: infant ratio**  
    - Special care: 1:2  
    - High dependency care: 1:1  
    - Intensive care (some babies requiring complex treatments may require 2:1)  

| **Standard 2** | The nursing establishment for children's intensive care and high dependency must reflect the level of care and interventions provided and the number of cots available. Units can provide a mix of services from high dependency care to basic and advanced levels of intensive care, requiring the following ratios of nurses to children:  
  * **Nurse: child ratio**  
    - Level 1 (high dependency): 1:1  
    - Level 2: 1:5  
    - Level 3: 2:1  
    - Level 4:  
    This ratio will rise to the next level where children are nursed in a cubicle. |
## Workforce planning and employment requirements (continued)

### Nursing establishment and skill mix by relevant professional bodies

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<td>3</td>
<td>Children's specialist services often provide treatment and care for children with specific groups of disorders, such as congenital cardiac disease, neurology or oncology. In these services, the nursing establishment must reflect the level of care and interventions provided, the number of cots or beds available and services provided to children outside the hospital setting.</td>
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<tr>
<td>4</td>
<td>Ambulatory care settings include emergency and outpatient departments, assessment and minor injury units and day care facilities. The nursing establishment and skill mix in ambulatory care settings should reflect the needs of the patients attending for treatment.</td>
</tr>
<tr>
<td>5</td>
<td>Operating departments where children are treated should employ nurses with the appropriate skills and competences to support surgeons and anaesthetists in the care of children. These nurses will ideally be registered children's nurses.</td>
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<td>6</td>
<td>Children and young people should have access to appropriately qualified nurses to support health care needs throughout their lifespan. This includes health visitors, school nurses and community children's nurses (CCN), as well as support staff such as health care assistants and play workers.</td>
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## Educating the children's nursing workforce

### A children's nursing qualification

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### Supporting students in practice settings

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### Continuing professional development and mandatory updates

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<td>2</td>
<td>All registered children's nurses must undertake continuous professional development relevant to the area in which the individual nurse works.</td>
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<td>3</td>
<td>The performance and progress of nurses’ development should be undertaken through regular appraisal and objective setting.</td>
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### Levels of mandatory safeguarding training for registered practitioners

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<tr>
<td>1</td>
<td>Training and education in safeguarding children is essential for every person working with children and young people. The level of training should be commensurate with the role of the individual.</td>
</tr>
</tbody>
</table>
Appendix:
Core standards to be applied in services providing health care for children and young people

1. The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff. See the RCN’s resources on supervisory ward sisters or team leaders at www.rcn.org.uk/publications

2. Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff.

3. At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need.

4. There will be a minimum of 70:30 per cent registered to unregistered staff (although the precise ratio will vary throughout clinical areas. For example, it is expected that there will be a higher proportion of registered nurses in areas such as children’s intensive care, specialist, and in many cases general children’s units).

5. A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave.

6. There should be a minimum of two registered children’s nurses at all times in all inpatient and day care areas.

7. Nurses working with children and young people (CYP) should be trained in children’s nursing with additional training for specialist services or roles.¹

8. Seventy per cent of nurses should have the specific training required for the speciality, for example, children’s intensive care, children’s oncology, children’s neurosurgery.

9. Support roles should be used to ensure that registered nurses are used effectively.

10. Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks.

11. The number of students on a shift should not exceed that agreed with the university for individual clinical areas.

12. Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels.

13. Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.

14. Where services are provided to children there should be access to a senior children’s nurse for advice at all times throughout the 24 hour period. A senior qualified children’s nurse is a nurse that holds a children’s nursing qualification, also has a master’s degree in an appropriate health/social care related subject, with a minimum of five years’ full time experience in uninterrupted clinical practice. The expectation is that this post would be at a minimum of band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children’s services must hold a registered children’s nursing qualification.

15. All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day.

16. Children, young people and young adults must receive age-appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs.

¹ Registered nurses who have completed learning disability and mental health nurse education programmes will have attained additional knowledge and skills by completing a recognised child-focused post-registration education programme to work with children and young people

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Useful websites

http://actionforsickchildren.org.uk/publications
http://mychildisinpain.org.uk
www.cqc.org.uk
www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility
www.independenthealthcare.org.uk
www.nhs.uk
www.nice.org.uk/nicemedia/live/13763/59578/59578.pdf
www.nmc-uk.org
www.rcn.org.uk
www.rcpch.ac.uk
www.wales.gov.uk/topics/health/nhswnes/healthservice/mental-health-services/measure/?lang=en
www.youngpeopleshealth.org.uk

Additional reading

Safeguarding

National Guidance for Child Protection in Scotland: Guidance for Health Professionals in Scotland
www.scotland.gov.uk/Publications/2012/12/9727

School Nursing

Royal College of Nursing (2009) School Nursing in 2009

Consent

www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html

Useful websites

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