Children and Young People’s Nursing at a Glance
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Children and Young People’s Nursing

at a Glance

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The education of children’s and young people’s nurses remains a foremost challenge for those wishing to ensure the accuracy and safety of the evidence base for practice. As long ago as 1952, Twistington-Higgins in his book written to commemorate the first 100 years of The Hospital For Sick Children, Great Ormond Street, London, UK, reiterates one of the original aims of the hospital dated 1852, which was: ‘To disseminate among all classes of the community but chiefly among the poor a better acquaintance with the management of infants and children during illness by employing it [The Hospital] as a school for the education of women in the special duties of children’s nursing’.

That initial aim of one of the early children’s hospitals resonates with contemporary children’s and young people’s nursing and Catherine Jane Wood, one of the early matrons of The Great Ormond Street children’s hospital left a tangible legacy of the importance of educating children’s and young people’s nurses in stating that ‘Sick children require special nursing and sick children’s nurses require special training’ (Wood 1888). In recognition of that laudable aim this new and exciting at a Glance book has been written by experienced practitioners and educators in a common quest to capture the complexities delivering nursing practice based on best evidence.

All children’s and young people’s nurses share a single esprit de corps which unites them with their colleagues worldwide and although this book is primarily reflective of children’s and young people’s nursing in the United Kingdom, others will find it an invaluable guide to the delivery of evidence-based nursing care.

Although the prime focus of the book is to illuminate best clinical practice, my fellow editors and I hope that the format of the at a Glance series will provide quick and easy access to important care delivery information packaged in an engaging and informative style. This book will be of interest to undergraduate student nurses and existing registrants wishing to remind themselves of the complexities of children’s and young people’s nursing which encompasses care delivery across the lifespan of the child from birth through to the emergence of the young person and future adult. In the pages of this book you will find concise information to help you deliver that care to this wide and disparate client group that makes up the landscape of contemporary childhood.

For those students wishing to test their knowledge and understanding of the content there is a comprehensive bank of multiple choice questions on the companion website.

This book could not have been completed without the organizational expertise and help of Brenda Nash. My fellow editors and I are in her debt.

Alan Glasper

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Key point boxes and red flag boxes draw your attention to important points.

The website icon indicates that you can find accompanying resources on the book’s companion website.

How to use your revision guide

Features contained within your revision guide

Each topic is presented in a double-page spread with clear, easy-to-follow diagrams supported by succinct explanatory text.

Key point

- The primary cause of cardiopulmonary arrest in young people is hypoxia. For this reason, if a young person is found unresponsive and not breathing the first action to be taken is for the rescuer to deliver five rescue breaths before seeking further help.

Red flag

- Effective ventilation and oxygenation may prevent a cardiac arrest from occurring in young people.
Section not available in this digital edition
Section not available in this digital edition
About the companion website

Don’t forget to visit the companion website for this book:

www.ataglanceseries.com/nursing/children

There you will find over 500 interactive multiple-choice questions which have been specially designed to enhance your learning.

Scan this QR code to visit the companion website.
Assessment and screening

Chapters

1. Assessment of the child 2
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Assessment of the child

Assessment is the gathering of information and formulation of judgements in partnership with the child and family. It is a continuous dynamic process and includes the physiological, physical, psychological, social and the spiritual aspect of the child and the effect that their health problems is having on their development and family life. Accurate assessment of the infant or child is essential to the delivery of safe and effective care. Depending on the child’s presenting condition, a focused assessment may be required in the case of the seriously ill child, necessitating prioritization of care until the child’s condition is stable.

Assessment leads to the identification of health problems and the development of care plans.

### Heart rate normal value

<table>
<thead>
<tr>
<th>Age</th>
<th>Awake</th>
<th>Deep Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn–3 mths</td>
<td>85–205</td>
<td>80–140</td>
</tr>
<tr>
<td>3 mths–2 yrs</td>
<td>00–180</td>
<td>75–160</td>
</tr>
<tr>
<td>2–10 yrs</td>
<td>60–140</td>
<td>60–90</td>
</tr>
<tr>
<td>&gt;10 yrs</td>
<td>60–100</td>
<td>50–90</td>
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</table>

### Respiratory rate normal value

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<thead>
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<th>Age (years)</th>
<th>Respiratory rate (breaths per min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>30–40</td>
</tr>
<tr>
<td>1–2</td>
<td>26–34</td>
</tr>
<tr>
<td>2–5</td>
<td>24–30</td>
</tr>
<tr>
<td>5–12</td>
<td>20–24</td>
</tr>
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</table>

### Rapid assessment

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A – alert</td>
<td>V – responds to voice</td>
<td>P – responds to pain</td>
<td>U – unresponsive</td>
<td></td>
</tr>
</tbody>
</table>

### Urinalysis

#### Subjective data:

Subjective data are ascertained from talking to the child and parent or carer

#### Objective data:

Objective data come from the findings of auscultation, vital sign recordings, inspection, percussion and palpation

### Weight

<table>
<thead>
<tr>
<th>Age</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn–3 mths</td>
<td>85–205</td>
</tr>
<tr>
<td>3 mths–2 yrs</td>
<td>00–180</td>
</tr>
<tr>
<td>2–10 yrs</td>
<td>60–140</td>
</tr>
<tr>
<td>&gt;10 yrs</td>
<td>60–100</td>
</tr>
</tbody>
</table>

### Length/height

<table>
<thead>
<tr>
<th>Age</th>
<th>Length/height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn–3 mths</td>
<td>85–205</td>
</tr>
<tr>
<td>3 mths–2 yrs</td>
<td>00–180</td>
</tr>
<tr>
<td>2–10 yrs</td>
<td>60–140</td>
</tr>
<tr>
<td>&gt;10 yrs</td>
<td>60–100</td>
</tr>
</tbody>
</table>

### Head circumference

<table>
<thead>
<tr>
<th>Age</th>
<th>Head circumference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn–3 mths</td>
<td>85–205</td>
</tr>
<tr>
<td>3 mths–2 yrs</td>
<td>00–180</td>
</tr>
<tr>
<td>2–10 yrs</td>
<td>60–140</td>
</tr>
<tr>
<td>&gt;10 yrs</td>
<td>60–100</td>
</tr>
</tbody>
</table>

### Blood pressure

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>70+ (age × 2)</td>
<td>lower limit of normal</td>
</tr>
<tr>
<td>90+ (age × 2)</td>
<td>upper limit of normal</td>
</tr>
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</table>

### Capillary refill time

Normal <2 seconds

### Level of consciousness

A – alert
V – responds to voice
P – responds to pain
U – unresponsive

### Systematic assessment

A rigorous approach to the collection of subjective and objective data. It entails examination and review of the systems of the body.
Assessment is the collection of data, both subjective and objective, which aims to achieve a complete picture of the child’s health status. Good assessment is a combination of the interpretation of physical data with the information gained from observation of the child and family and from listening to them.

Interviewing – history taking
Gaining the trust of the child and family is an essential element in developing an effective therapeutic relationship. Introducing yourself to the child and family with explanations of expected outcomes will put the child and family at ease. Age appropriate language should be used. Questions should be directed at both the child and parent. Young people should have an opportunity to talk in private if they wish. When taking a history, a structured approach should be used. This needs to include:
- Presenting complaint
- History of presenting complaint
- Past medical history (birth and neonatal history in infants and young children), immunizations, illnesses and hospitalizations
- Allergies
- Current medication
- Developmental history
- Family history
- Social history – nursery, school.

Observation – subjective data
Subjective data are what the child and parent say along with the visual information gained from the initial encounter with the child and family or while obtaining objective data (physical examination and recording of vital signs). This includes noting:
- The colour of the child: are they pale, mottled, cyanosed, jaundiced, flushed
- Behaviour: alert, crying, agitated, combative, lethargic, drowsy
- Interaction with parents/carers/strangers
- Interaction with environment, wanting to play or sleepy
- Position: normal, floppy or stiff
- The general appearance of the child: e.g. unkempt or clean
- Obvious birthmarks, bruises or rashes
- Dysmorphic features.

Measuring – objective data
All infants and children require a baseline physical assessment. This is a multifaceted process and some aspects are common to all children who require assessment of their health status. The physical assessment is concerned with the analysis and interpretation of data. Privacy and dignity should be maintained during this process. Consent should be obtained prior to undertaking a physical assessment.

Physical assessment includes:
- Basic physical recordings of temperature, pulse rate, respiratory rate, oxygen saturation and blood pressure
- Respiratory assessment, rate of breathing, depth of breathing, noise of breathing, presence of cough, chest movement, nasal flaring, use of other accessory muscles, child’s colour, ability to speak/feed, position of the child, peak flow and oxygen saturation level
- Heart rate including pulse volume
- Capillary refill time
- Neurological status using Glasgow coma scale or AVPU
- Level of hydration: obvious signs of dehydration include sunken anterior fontanelle, dull sunken eyes, dry oral mucosa, lethargy, weak cry, decreased urinary output
- Weight
- Height/length
- Head circumference
- Skin assessment using recognized pressure risk assessment tool
- Urinalysis.

All findings need to be documented as they are a legal record of the nursing assessment, the foundation on which care is planned and the basis of communication with multidisciplinary team.

Summary
Assessment is a dynamic continuous process that needs to include the child’s and parent or carer’s perspectives. Observation is as essential as physical assessment and good communication skills are important.
Part 1  Assessment and screening

SBAR framework

SBAR is a flexible framework which is widely utilized in health care settings to focus and facilitate communication amongst health care professionals, allowing assessment and management of risk in the care of the acutely ill child or young person (Figure 2.2). This tool enables effective and assertive sharing of information and cultivates a safe approach to patient care. SBAR is an adaptable structure that can be used to shape communication pathways at any stage of a patient’s journey, whatever the clinical setting (Institute for Healthcare Improvement).

Figure 2.1   SBAR framework

Situation – What is currently going on with the patient?
Background – What are the circumstances leading up to the situation?
Assessment – What is the problem or concern?
Recommendation – What do you think should happen next?

Furthermore, in using this tool the health professional is able to identify areas of concern with cognisance of the existing and previous history of the patient’s condition. Subsequently, assessing the impact of current issues relating to patient care and making clinical decisions, based on best available evidence, including recommendations of what is required in terms of actions to ensure patient safety and well-being.

Figure 2.2   Simulated scenario using the SBAR tool

Chloe is a 10-month-old baby weighing 9 kg, with a history of gastro-oesophageal reflux (GOR) and faltering growth, which is currently being managed with supplementary enteral feeding via a nasogastric tube (NGT). In addition to this, Chloe has been prescribed oral omeprazole once daily to help manage her GOR. This scenario is explored in greater depth utilizing the SBAR tool to enhance understanding of risk and its effective management.

Summary

The scenario illustrates the utilization of SBAR in the care of Chloe to ensure and maintain her safety, through effective inter-professional communication and patient care. When used appropriately, the SBAR tool is effective in supporting and delivering safe care in a timely manner.

As highlighted by Morrow (2012), this simple framework creates prompts for the user in relation to situational awareness in clinical scenarios and communicating critical information to other health professionals:
**Inter-professional working**

SBAR is a valuable communication tool when used either uniprofessionally or inter-professionally. For example during clinical placement the practice mentor may utilise this SBAR tool to provide feedback on the nursing student's ability to prioritise using this flexible framework, when reporting on a patients’ condition and on their theoretical knowledge and problem-solving skills.

Additionally, effective understanding of collaboration and inter-professional working are essential elements within healthcare education and practice. During simulated inter-professional learning sessions, nursing and medical students are encouraged to reflect upon this situational briefing tool, which guides them to communicate important information in a predictable structure, when summoning senior nursing or medical help with a deteriorating child (Morrow 2012).

**Communication barriers**

The quality of communication between and with patients and healthcare professionals is a critical factor in establishing safe and effective care. Therefore, it is essential that everyone involved within the healthcare team communicates effectively, in order that maximum standards of care can be supported and achieved.

Within the healthcare environment practitioners need to be mindful of language and literacy barriers which may directly or indirectly affect the decision-making process and effectiveness of the communicated message. However, having clear shared goals, role awareness of individual professions and the ability to work independently within a team as well as working together should assist in removing these barriers.

**When using SBAR tool the practitioner should aim to:**

- Communicate effectively
- Identify priorities
- Utilise decision-making strategies
- Develop problem-solving skills
- Be aware of language and literacy barriers.
The nursing process

Nursing has a theoretical base that has many elements including physiology, psychology, pathology, pharmacology and sociology. To deliver quality care to patients that is focused, safe and organized, it needs to be planned. Documenting the plan of care for a patient and its implementation ensures continuity of care and provides a legal document demonstrating that care has been delivered. Care can be organized using the nursing process and nursing models can help focus care to meet the specific needs of patients.

**What is nursing theory?**

Nursing theory is the cognitive knowledge and understanding that is used by practitioners to help them deliver the best possible care based upon best evidence. Nursing theory is partly drawn from a range of subjects from the arts and sciences and can be applied to the practice of nursing (Colley 2003)

**Key point**

Nursing theory is knowledge that comes from experiential learning and research and is used by the nurse to guide practice

**What are nursing models?**

- Nursing models are a combination of theories and concepts that provide a framework to assess, plan, implement and evaluate care
- Many nursing models proposed by theorists (Chalmers 1990)
- Most common are those that include 'activities of daily living'
- Casey's partnership model being based upon the notion of partnership with the family where parents or carers provide care until the child or young person is mature enough to do it themselves

There are several models that are commonly used in the nursing of sick children and young people (Table 3.1). The most common are 'activities of daily living models' which include Henderson (1978), Roper, Logan and Tierney (1983) and Orem (Aggleton and Chalmers 2000). Additionally, a further model is applied to the care of sick children and can be used in conjunction with other models that were essentially designed for adults. Casey's (2007) model for children's nursing is all about partnership and has become standard practice in UK children's units. The central premise of these activities of daily living models is that normally people maintain their own functions in these areas but in times of illness these may be compromised and require support from health care professionals. In the case of children, some activities of daily living such as keeping the body clean may be compromised simply by developmental age. This is why children's nurses have adopted Casey's theoretical framework based on the notion of partnership and in turn on the philosophy of children's nursing and the notion of the indivisible family unit where parents or carers provide essential care until the child is mature enough to do it themselves. Orem's model is sometimes called the self-care model and is oriented towards restoring an individual to a health status where self-care is possible. It is particularly useful in rehabilitation settings (e.g. after childhood head injury).
What is the nursing process?

The nursing process is a framework for organizing individualized nursing care. It involves four stages: assessment, planning, implementation and evaluation (APIE). The intention of the nursing process is to enable continuity of care by thorough documentation of information, to provide continuous observations and ensure effective interventions. However, there has been a much criticism of the nursing process approach to care as it imposes rigid constraints on practice, is cumbersome and outdated (Walsh 1997).

Care plans provide an excellent means through which the rights of children and their families can be respected. They enable children and families to be fully informed and share in decision-making about their care (United Nations 1991; RCN 1992). The involvement of children and families in the planning and implementation of care is recognized by professional bodies as vital in the formation of effective partnerships with families and children in the provision of care and health care services (RCN 1994).

The Nursing and Midwifery Council (NMC) require nurses to respect the patient or client as an individual and recognize and respect the role of patients and clients as partners in the contribution they can make. This includes identifying their preferences regarding care (NMC 2008). The primary rationale for using the nursing process is the creation of a care plan that is used to determine the nursing care given to an individual patient. An essential component is that the goals or objectives of the care plan are measurable to enable care to be evaluated and improved upon.

The nursing process can be perceived as the cognitive vehicle for planning the coordination of care delivered to a patient. Universally, it is the language of nursing and wherever nurses work they will use the same basic steps which constitute the nursing process (i.e. care delivered using four steps: APIE or Soapie). It is important to remember that patient care must be documented and every child should have an individual plan of care that has been determined following a full nursing assessment. In legal terms, if it was not documented it never happened.

Planning care

Nursing care has always been planned. However, in recent times the focus of care has changed from the completion of tasks to the provision of holistic care where patients are viewed as individuals with diverse and individual needs (Walsh 2001). Planning care should involve, where possible, the child and family to uphold the overarching family-centred care philosophy of children's and young person's nursing. Planning care involves reviewing all of the identified needs or patient problems and prioritizing them. Glasper (1990) discusses how Maslow's hierarchy of human needs can help nurses objectively plan nursing care. Clearly, if a child has compromised respiratory efforts this must be prioritized before planning dietary intake for example. Care plans are frameworks through which nurses apply the nursing process in addressing the needs of their patients. A nursing care plan is a written statement of the patient's nursing problems and the measures that will be used to effect a solution or mediate these problems (Johnson 1980, cited in Hurst 1993).

Care pathways or critical pathways involve the multidisciplinary team involved in the treatment and management of a patient and provide a programme of care delivery. They provide care that is focused, cost effective and collaborative (Herring 1999). For each clinical problem, the essential steps involved in the care of the patient are set out and planned with regard to that individual's expected progress. They provide a plan of desired patient outcomes, linked to an estimated time frame and the resources available. They can assist in the application of national evidence-based guidelines into local practice. Care pathways have the advantage of improving teamwork, reducing duplication of documentation and provide continuous records of care for a patient (Norris & Briggs 1999). When using care pathways or predetermined care care plans it is important these should still be individualized. Some NHS Trusts have care-planning software that allows nurses to plan an e-care plan for each individual child. When planning care nurses must ensure that the goals of care are achievable.

Summary

The nursing process can be applied in any nursing health care situation and offers a cognitive toolkit to assess, plan, implement and evaluate care. It is easy to use because it is systematic. However, in practice it requires a number of nursing skills: a good understanding of how health problems can impact on an individual child with reference to pathophysiology and social science; excellent interpersonal skills of communication with well-developed listening skills; and technical proficiency in delivering care based on best evidence.
4 Nursing models

Figure 4.1 How to implement nursing models into practice

- Used as part of preceptorship or mentorship, clinical supervision to explore nursing actions in more depth
- Development of a personal toolkit using a range of nursing models
- Incorporated into reflective practice

Use of nursing models in practice settings

- As part of the philosophy of care
- As part of multidisciplinary working
- In conjunction with care pathways and guidelines
- As a framework for care planning

Figure 4.2 Suggested activities

1. Reflect on a shift, referring to three nursing models outlined in this chapter; – i.e. Is there any indication of use of any of these?

2. Find out a bit more about the three nursing models and compare this to with your reflection. Think of ways in which your newly gained knowledge could enhance your practice.

3. Find out about two other nursing models not mentioned in this chapter. What are their strengths and how could they be used to develop your practice?
Nursing models are theoretical frameworks, first developed in the 1950s to provide guidance on the delivery of nursing care. There are many different types; however, they all provide direction on how to implement the care for an individual. A nursing model contains concepts, processes and goals that guide care delivery. They are seen by some as being too traditional and not always suited to contemporary care provision; this is because of the continuing drive towards evidence-based practice, which is often based on hard scientific facts.

Models are extremely important in the development of nursing practice, providing direction to children and young people’s nurses when planning, implementing and evaluating care. They can be utilized in all settings where children and young people receive care. All nursing models have a focus on meeting the needs of an individual; however, the way that this is defined varies considerably. The models most frequently used are discussed here but there are many others that can also be considered which assist in providing high-quality care that meets the needs of the child and family. A ‘pick and mix’ approach is helpful, as many nurses find that they draw on more than one nursing model in their practice.

**Nursing models used in children and young people’s nursing**

The partnership model, which was developed in the United Kingdom by Anne Casey in the 1980s, is one that is often most closely identified with children and young people. Unlike many nursing models, it was developed for this specific group, the main focus being the concept of family-centred care. Roper, Logan and Tierney (1985) created the activities of daily living. This is a conceptual model which uses 12 activities of living as the central component with five underpinning factors: biological, psychological, socio-cultural, environmental and politico-economic. Orem's self-care model is based on meeting the self-care needs that the person is unable to meet themselves. Each person has universal self requisites based on human functioning (e.g. a sufficient intake of food), each person has developmental self-care requisites linked to their stage in life, and they also have self-care requisites that arise from their health issue.

**How nursing models can be used in practice**

All nursing models have a theoretical base. By exploring these concepts, nurses can build on their knowledge base to develop their expertise in becoming caring and compassionate practitioners. Nursing models are often incorporated into care planning. This can be implicit; the philosophy of the partnership model may be used to inform practice but not be directly visible in the care setting. Roper, Logan and Tierney’s activities of daily living model (1985) is often easy to detect, for example in admissions documentation. This has led to criticism that it has been reduced to a tick box approach which detracts from a model that has a lot to offer in furthering our understanding of individualized care. It would be unusual to see Orem’s self-care model being used directly in practice, but on closer inspection it is often integrated into the care plan, such as encouraging the child and family to take control of their health which is part of the systems approach advocated by Orem.

**Summary**

Nursing models are theoretical frameworks. Individual practice can be enhanced by applying nursing models in all aspects of care. Evidence-based practice requires an individualized approach and use of nursing models can help to achieve this. Nurses should be encouraged to explore different nursing models and have a flexible approach towards combining them in practice.
### The care plan

#### Figure 5.1 Care plan framework

<table>
<thead>
<tr>
<th>Identified problem/need</th>
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<tbody>
<tr>
<td>• The need should have been clearly identified during the assessment</td>
</tr>
<tr>
<td>• The problem/need should be individualized</td>
</tr>
<tr>
<td>• The problem/need covered should be specific, so that if three needs or problems are identified during the assessment, there should ideally be three care plans</td>
</tr>
<tr>
<td>• The child and his/her carers need to be involved in the identification of their needs – they are the ‘expert’ in how the illness makes them feel and the impact it has on the family unit</td>
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<thead>
<tr>
<th>Short-term goals</th>
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<tbody>
<tr>
<td>• Often used when a period of assessment is needed (e.g. the child is acutely unwell)</td>
</tr>
<tr>
<td>• Should be SMART (specific, measurable, achievable, realistic and time-specific)</td>
</tr>
<tr>
<td>• Should be mutually agreed by and acceptable to the child and his/her carers</td>
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<tr>
<td>• Should be clear and concise</td>
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<tr>
<th>Long-term goals</th>
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<tr>
<td>• Should be SMART</td>
</tr>
<tr>
<td>• Should be mutually agreed by and acceptable to the child and his/her carers</td>
</tr>
<tr>
<td>• Should be clear and concise</td>
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<tr>
<th>Interventions</th>
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<tbody>
<tr>
<td>• The child and his/her carers should work in collaboration with the nurse to ensure the interventions are individualized, specific and meet the needs of the child</td>
</tr>
<tr>
<td>• The practitioner leading on each of the interventions is skilled and competent to carry them out</td>
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<tr>
<td>• Interventions should be prioritized to meet the needs of the child and his/her carers</td>
</tr>
<tr>
<td>• The interventions identified should have a theoretical base</td>
</tr>
<tr>
<td>• The practitioner should consider cultural diversity and well as gender, age appropriateness and religious beliefs when planning any intervention</td>
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<tr>
<td>• The core principles of care, compassion, dignity, privacy and quality, should underpin clinical practices</td>
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<tr>
<th>Evaluation</th>
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<tbody>
<tr>
<td>Remember that evaluation should happen continuously</td>
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<tr>
<td>It should include the child and his/her carers</td>
</tr>
<tr>
<td>It should provide clear evidence as to whether the interventions are making a difference</td>
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<tr>
<td>It should provide an overview of the child’s condition in order to modify care</td>
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<tr>
<th>Review date</th>
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<tr>
<td>Essential in order to measure care outcomes in a timely manner</td>
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#### Figure 5.2 Common care planning problems

- **Incomplete initial assessments** – leading to gaps in care and increased levels of risk
- **Unrealistic care planning** – could give false hope, or increased level of expectation about the child’s outcome
- **Lack of clear goals and vague interventions** – leading to difficulties in evaluating care
- **Not individualized** – may lead to inappropriate clinical intervention

#### Figure 5.3 Example – care plan

**Scenario**

Jane is 23 and has two children: James who is 4 years and Madelaine who is 18 months. Jane lives by herself with the children and has very little social or family support. Jane calls you and requests a Health Visitor meeting. You arrange to see her at the family home. When you arrive, Jane expresses her concern about James’ sleep pattern. She is struggling to get him to bed before 11pm. When he is in bed, James takes a further 30–60 minutes to settle, often disrupting Madelaine. James gets angry at bedtime, he shouts, screams and kicks so that Jane does not follow through any routine. Jane tells you that he hates bedtime and is old enough to stay up late to watch the television. He denies feeling tired. James is due to start school in September.

<table>
<thead>
<tr>
<th>Identified problem/need</th>
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<tbody>
<tr>
<td>James lives with his mum and sister in the family home. He is 4 and is due to start school in September. James is not going to bed until 11pm most nights, and when he is in bed does not settle until 11.30pm –12am. Prior to bedtime James shouts, kicks and screams, often disrupting Madelaine. James gets angry at bedtime, he shouts, screams and kicks so that Jane does not follow through any routine. Jane tells you that he hates bedtime and is old enough to stay up late to watch the television. He denies feeling tired. James is due to start school in September.</td>
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<tr>
<th>Goals</th>
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<tr>
<td>To assess potential bio-psycho-social issues that may prevent James from wanting to go to bed. For James to have an established sleep routine that ensures flexibility.</td>
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<tr>
<th>Interventions</th>
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<tr>
<td>• For James to be allowed to talk about bedtime – identifying any fears or concerns he may have about this aspect of his daily routine</td>
</tr>
<tr>
<td>• To provide James with reassurance in relation to any issues identified, referring on to specialist services as required</td>
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<tr>
<td>• To support Jane in purchasing aids/equipment that may support a new bedtime routine (e.g. new duvet cover of James’ favourite cartoon character, night time light, bedtime books)</td>
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<tr>
<td>• To ensure the bedroom environment is supportive of sleep</td>
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<tr>
<td>• Discuss daytime routine with Jane and identify how James could increase his activity levels</td>
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<tr>
<td>• To develop a bedtime routine with Jane – one that is consistent and appropriate for James’ age</td>
</tr>
<tr>
<td>• To ensure the bedroom environment is supportive of sleep</td>
</tr>
<tr>
<td>• To discuss how James can cope with the stresses of providing James with a boundaried approach to bedtime</td>
</tr>
<tr>
<td>• To discuss how James will be rewarded when small achievements are made</td>
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<tr>
<th>Evaluation</th>
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<tr>
<td>1 July 2013: developed the care plan with James and his mum today, James’ opinion was sought. He did not think he should be going to bed any earlier but did add that he would like to go to the park more often. Jane was in agreement. I have left a copy of the care plan with the family so Jane can read it and add any further comments. Jane has requested that we meet again in a week. An appointment has therefore been arranged for 8 July at 2.30pm.</td>
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<tr>
<th>Review</th>
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<tbody>
<tr>
<td>The care plan is to be reviewed after each visit</td>
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