POCKET GUIDES

CHILDREN'S NURSING PLACEMENTS

Valerie Denieul
and Julia Robinson

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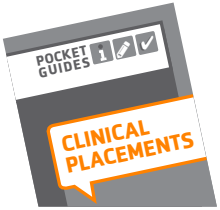
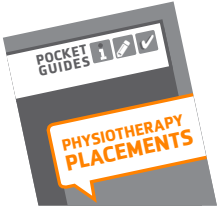


"A very useful, well-written and practical pocket book for any level of student nurse preparing for clinical placement. This book is also a great resource for lecturers and mentors to have, to help students get the most out of their placement time." ★★★★★

"This is such a useful guide that has just the right amount of need to know info for student nurses on clinical placement, as well as loads of little tips scattered throughout. A must-have for student nurses on placements!" ★★★★★

"Full of everything you need to know as a student nurse on placement. Written by students for students. Helpful little references to help with abbreviations and common medications. A must for any student about to head on placement." ★★★★★



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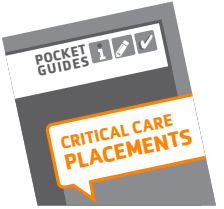

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University of Central Lancashire

ISBN: 9781908625618
First published in 2019 by Lantern Publishing Limited

Lantern Publishing Limited, The Old Hayloft, Vantage Business Park, Bloxham Road, Banbury OX16 9UX, UK
www.lanternpublishing.com

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Typeset by Medlar Publishing Solutions Pvt Ltd, India
Printed and bound in the UK

Last digit is the print number: 10 9 8 7 6 5 4 3

Personal information

Name: . . . . . .

University email: . . . . . .

Academic advisor: . . . . . .

PLACEMENT DETAILS

Placement area: . . . . . .

Placement address: . . . . . .

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Link lecturer: . . . . . .

PLACEMENT DETAILS

Placement area: . . . . . .

Placement address: . . . . . .

. . . . . .

Link lecturer: . . . . . .

CONTACT IN CASE OF EMERGENCY

Name: . . . . . .

Contact number: . . . . . .

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Moving on from there

Preface

This pocket guide to clinical placements has been especially developed for Children's Nursing students. It acknowledges that Children's Nursing is a highly specialised area very different to Adult Nursing, and that children are not just little adults!

As lecturers in Children's Nursing we prepare students for clinical placement and as academic advisors we understand the challenges that you might face there. To give you a rounded perspective, we have also included some top tips from students who have been on clinical placements already.

As a Children's Nursing student, you may experience a wide range of placement types in both clinical and community settings. Examples of clinical settings include the hospital ward, accident and emergency department, neonatal unit, paediatric critical care and children's hospice. In the community you could be placed with Health Visitors, School Nurses and community paediatric outreach teams. This guide is written to provide support for both clinical or community placement settings.

Valerie Denieul and Julia Robinson

Children's Nursing Team,
University of Central Lancashire

Acknowledgements

We would like to thank:

- Students and former students Ella Barker, Siobhán Beline, Josephine Farrell and Ellie Field (University of Central Lancashire) for their contributions from the Student Nurse perspective
- Kirstie Paterson, Jessica Wallar and Kath MacDonald (the authors and editor of *Clinical Placements* Pocket Guide, the adult nursing book we built on)
- The Senior Leadership Team at the School of Nursing, University of Central Lancashire for their support for this project
- Joseph Robinson, aged 6, and Romy Denieul, aged 9, for their illustrations.

Abbreviations

Note that these can vary between clinical areas!

Abbreviations can sometimes mean different things in different circumstances; e.g. OD in prescribing means 'once daily', whereas in other settings it can mean 'overdose'. It is for this reason that the NMC Code suggests avoiding the use of abbreviations.

A&E	accident and emergency
ABC	airway, breathing, circulation
ADL	activities of daily living
ANTT	Aseptic Non Touch Technique
AVPU	alert, voice, pain, unresponsive
BF	breastfeeding
BLS	Basic Life Support
BNO	bowels not opened
BO	bowels opened
BP	blood pressure
C&YP	children and young people
CAF	Common Assessment Framework
CBG	capillary blood gas
CCU	clean catch urine
CD	controlled drug
CIN	child in need
CLA	child looked after
CNS	clinical nurse specialist
CP	child protection
CPR	cardiopulmonary resuscitation

CRP	C-reactive protein
CRT	capillary refill time
CSF	cerebrospinal fluid
CSU	catheter specimen urine
DNAR/DNR/DNACPR	do not attempt resuscitation
DOB	date of birth
DV/DA	domestic violence / domestic abuse
EBM	expressed breast milk
ECG	electrocardiogram
EEG	electroencephalogram
ENT	ear, nose and throat
EPR	electronic patient record
ETT	endotracheal tube
FBC	full blood count
FCC	family-centred care
FII	fabricated or induced illness
GCS	Glasgow Coma Scale
GI	gastrointestinal
HNPU	has not passed urine
HR	heart rate
HV	Health Visitor
ICP	intracranial pressure
IM	intramuscular
IV/IVI	intravenous / intravenous infusion
LOC	loss of consciousness
LOS	length of stay
LOTA	limitation of treatment agreement
MRSA	meticillin-resistant *Staphylococcus aureus*
MSU	midstream specimen of urine

NAD	no abnormality detected
NAI	non-accidental injury
NBM	nil by mouth
NG	nasogastric
NICU	neonatal intensive care unit
NJ	nasojejunal
NMC	Nursing and Midwifery Council
NSAID	non-steroidal anti-inflammatory drug
O_2	oxygen
OCP	ova, cysts and parasites
OG	orogastric
OJ	orojejunal
PBLS	paediatric Basic Life Support
PCHR	Personal Child Health Record (the 'red book')
PEARL/PERL	pupils equal (and) reactive to light
PED	paediatric emergency department
PEF	Practice Education Facilitator
PEG	percutaneous endoscopic gastrostomy
PEWS	Paediatric Early Warning Score
PHDU	paediatric high dependency unit
PICC	peripherally inserted central catheter
PICU	paediatric intensive care unit
PO	taken orally
PPE	personal protective equipment
PR	given rectally
PRN	given as required
PU	passed urine
RR	respiratory rate

SBAR(D)	situation, background, assessment, recommendation (decision)
S/C	subcutaneous
SOB	shortness of breath
SpO_2	peripheral capillary oxygen saturation
Ts & As	tonsils and adenoids
TAF	team around the family
TPN	total parenteral nutrition
TPR	temperature, pulse, respirations
U+E	urea and electrolytes
URTI	upper respiratory tract infection
USS	ultrasound scan
UTI	urinary tract infection
VIP	visual infusion phlebitis
VTE	venous thromboembolism
WOB	work of breathing

14 Personal safety

14.1 Hand hygiene

Top tip

Remember that effective hand hygiene is the number one intervention we can make as healthcare professionals to protect our patients from the spread of healthcare-associated infections.

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

Apply a palmful of the product in a cupped hand, covering all surfaces;

Rub hands palm to palm;

Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;

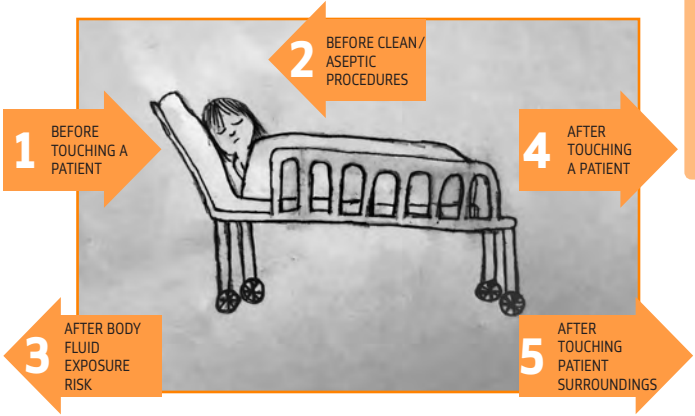
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

Once dry, your hands are safe.

Proper hand rub technique (World Health Organization, 2009). Reproduced with permission of the World Health Organization, www.who.int.

Directions for hand washing (World Health Organization, 2009):

- Wet hands with water
- Apply soap
- Rub hands together (palm to palm)
- Interlock fingers, alternating hands (palm to palm and top of hand to palm)
- Back of fingers to opposing palms with fingers interlocked
- Rub each thumb thoroughly
- Circular motion of fingertips in opposite palm
- Rinse hands with water
- Dry hands thoroughly with a single use paper towel
- Use towel or elbows to turn off taps.



My Five Moments for hand hygiene. Adapted from *Journal of Hospital Infection*, 67(1), Sax, H. *et al.*, 'My five moments for hand hygiene': a user-centred design approach to understand, train, monitor and report hand hygiene, pp. 9–21 (2007). Image adapted for children's nursing. For more information visit **bit.ly/WHO-M5M**

If you see someone who does not abide by the proper hand hygiene rules, including parents, carers and visitors, remember it is our job to advocate for our patients and it is important that we become comfortable asking people to perform hand hygiene. There are different ways to approach this and with experience you will feel more comfortable raising this with colleagues. Parents and family members may need reminding about the importance of hand hygiene in a hospital setting, as it is different to caring for their child at home.

14.2 Infection control and sharps policy

Hospital bins are colour-coded according to the type of waste that should go in them. It is important to know what waste goes in what bin. This is an example, but check your local policy.

Colour of bin bag or container	Type of waste
Black	Non-infectious 'household' waste, packaging
Yellow	Hazardous and infectious clinical waste, e.g. gloves and aprons, swabs, dressings
Yellow with black line (tiger)	Offensive, non-infectious clinical waste, e.g. nappies, pads and incontinence sheets (often known as inco sheets)
Orange	Infectious clinical waste dressings, e.g. dressings, waste in isolation rooms
Purple	Cytotoxic waste: items contaminated with chemotherapy, including nappies

Any waste containing confidential information is disposed of in a dedicated bin, to be later shredded.

The use of personal protective equipment (PPE) is essential for health and safety (NHS Professionals, 2016).

PPE includes: gloves, aprons/gowns, face protection, mouth/eye protection.

Often there are colour-coded aprons/gowns for various activities; for example, for serving food, for checking medication and for patient care. See your local policy. Ensure that the aprons are changed when necessary, e.g. between tasks or patients.

Activity	Apron or gown	Gloves	Face, eye/mouth protection
Contact with intact skin	Yes if the patient is infectious	Yes if the patient is infectious	N/A
Washing patients	Yes	Risk assessment	N/A
Feeding a patient	Yes	Risk assessment	N/A
Bed making, dressing patients	Yes	Risk assessment	N/A
Potential exposure to blood or body fluids	Yes	Yes	Risk assessment
Changing nappies	Yes	Yes	N/A
Oral care	Yes	Yes	Risk assessment
Suction	Yes	Yes	Risk assessment
Handling specimens	Yes	Yes	Risk assessment

Activity	Apron or gown	Gloves	Face, eye/ mouth protection
ANTT and sterile procedures	Yes	Yes	Risk assessment
Contact with wounds and skin lesions	Yes	Yes	Risk assessment
Using disinfectants, cleaning agents	Yes	Yes	Risk assessment
Handling waste	Yes	Yes	Risk assessment

Sharps bins

- Any sharp instruments must be placed in a 'sharps bin' after use.
- Remember to always have a sharps bin within reach when handling sharp materials such as a needle, in order to dispose of it immediately.
- Always dispose of your own sharps, and never someone else's sharps.
- Never re-sheath a needle.

Other bins you may see on placement

- Purple sharps bins: for cytotoxic and cytostatic contaminated waste
- Glass bottle bins
- Oral medication syringe bins.

See your local policy and ask!

Tips for if you get a needle-stick injury

- Tell your practice supervisor or someone you are working with.
- Wash the cut immediately with running water while milking the wound to make it bleed.
- Cover as applicable.
- Get medical advice straight away at Occupational Health or A&E, as per your placement policy. They will be able to instruct you on the necessary steps and whether you need blood tests/vaccinations, based upon the type of exposure.
- Never be afraid of telling someone. Your safety should be your priority.
- File an incident report depending on policy in your placement area (remember policies may vary between areas).

Notes

14.3 Moving and handling

Musculoskeletal injuries such as back pain are a serious problem within the nursing profession so it is essential that we use approved techniques when we are moving and handling patients. This helps to protect both patients and ourselves from injury.

Assessing risk with TILE

Before carrying out any moving and handling task, whether you are helping a patient get out of bed or need to carry a box, you must always assess risk.

Task	What do you want to do/achieve? e.g. assist the patient out of bed.
Individual	What are your individual capabilities? Consider your own health – for example, do you have any existing health conditions or injuries, are you pregnant? Consider the abilities of your colleagues who may also be involved.
Load	This refers to the patient or object. Additional equipment may be required, e.g. manual handling aids, additional pillows, sliding sheets, hoists.
Environment	Consider the space/environment that you are working in – you may have to remove any potential hazards.

Notes

Factors to consider before you begin moving a patient

- Have I communicated with the patient and family and explained what is about to happen? Did I get their consent to move them?
- Is this the right time to move the patient? For example, do they need pain relief first? Have they just had a feed they might vomit if they are moved?
- Can the patient help move themselves? Are they weight bearing?
- How are you going to approach this? What is the correct way? Do you need help from others? Is there a physiotherapy input?
- Is the bed space cluttered, do you need to make room to move your patient safely?
- Does the child have devices such as IV infusions, drains or catheters? Have they been safely secured before movement?
- Gather additional equipment needed before moving: wheelchair, pillows, appropriate footwear.
- Make use of the bed height function, where appropriate, to help your patient mobilise to their chair or pushchair.
- Children with complex physical needs: take advice from the child and/or parents on how best to help them move and reposition. These children are at extra risk of injury, fractures and pain when moving, so take special care and get help as required.
- Maintain dignity when moving a patient – close curtains and provide covers.

Tips on moving a patient

- Think about your own body position when moving and handling patients, objects and equipment.
- Continuously assess personal and patient risks.
- If a patient looks like they are about to fall – don't catch them or try to keep them up. Assist them to the floor if it is safe to do so and seek help.

- If a patient falls, do not attempt to lift them off the floor manually. Either the patient will get up independently with some guidance, or a hoist (or other appropriate equipment) should be used to raise the patient.
- If you're unsure about how to move any patient, seek advice from your practice supervisor or colleagues – including your placement area's physiotherapist.
- Always remember to communicate with the patient and explain what you are doing.
- When doing bedside care: cot sides and bedrails should be at a comfortable level to prevent you over-reaching; however, be mindful of patient safety and ensure that an infant or child cannot wriggle off the bed! Remember to put the sides up again after cares.
- Consider the bed or cot height – are you working at a comfortable level so that you are not stooping or reaching? Always return the cot or bed to the lowest height setting after cares are completed.

Notes

WHO (2018) *SAVE LIVES: Clean Your Hands*. Available at **bit.ly/WHO-CYH**

NHS Professionals (2016) *Standard Infection Prevention & Control Guidelines*. Available at **bit.ly/SICP2016**