



Department of Nursing Studies
Department of Primary Health Care

NST 218 RETURN TO PRACTICE

Paediatric Nursing
- branch update

PAEDIATRIC NURSING

TABLE OF CONTENTS

INTRODUCTION	3
PAEDIATRIC NURSING - THE ENB'S EXPECTATIONS	4
CARING FOR CHILDREN IN THE NHS	8
FAMILY-CENTRED CARE	11
CHILD PROTECTION	16
CONSENT, CONFIDENTIALITY AND ADVOCACY	26
MANAGEMENT OF PAIN IN CHILDREN	29
CHRONIC ILLNESS	39
CARING FOR CHILDREN WITH ACUTE ILLNESS	45
REFERENCES	50

FAMILY-CENTRED CARE

One result of the emphasis on holistic health care for children, one taking more humanistic approaches, has been a recognition of the need to balance the medical model of care with greater awareness of the social sciences. This has led to the developments of the concept of *family-centred care*.

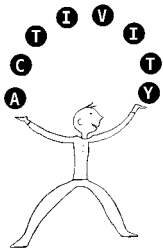
This has not yet developed to the level of a model or framework, but is an approach being used to ensure that holism in children's nursing includes the *whole family* as being integral to the health of the individual child. It is described as a philosophy by Campbell (1993), and by Marlow (1977) as having "*its roots in the Orient where the whole family becomes involved in the care of the sick.*" Brunner and Suddarth (1981) suggest that:

"Family-centred care provides an opportunity for the family to care for the hospitalised (child) under nursing supervision."

and

"the goal of family-centred care is to maintain or strengthen the roles and ties of the family with the hospitalised child in order to promote normality of the family unit."

Family-centred care also acts as a way of achieving the aims of the Patient's Charter and the rights of the child and the family established by the Children's Act (1989).



Read about family-centred care using the following:

Campbell, S. (1993) - Keeping it in the Family: defining and developing family centred care. *Child Health*, June/July 1993.

Mason, P. (1993) - First for families. *Nursing Times* 89 (24): 34 - 36.

Dearmun, A. (1992) - Perceptions of parental participation. *Paediatric Nursing*, 4 (7): 6 - 9.

Dinard, B. (1990) - Parental Acts and Omissions. *Paediatric Nursing*, Feb 1990.

Palmer, S. J. (1993) - Care of sick children by parents: a meaningful role. *Journal of Advanced Nursing* 18: 185 - 91.

Have a look also at the appropriate chapter in the Whaley & Wong book listed at the end of the Campbell article.

Paediatric Nursing

What do you think are the key implications of family-centred care for you and your work? The Dinard article is particularly useful on legal issues.

Family-centred care

Your notes

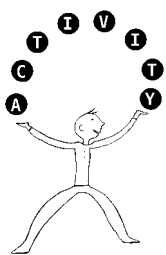
Sample page

CHILD DEVELOPMENT - A REFRESHER

WHAT IS A 'CHILD'?

Is a six month old baby a child yet? Is age a determinant of being a child? Or is it something to do with level of development? Or sexual maturity?

Perhaps it's a legal issue: at 16 we can work full time; at 18 we can vote and drink alcohol, so does that make us no longer a child? It's not so long ago that 'children' left school at 14, and only 100 years ago that 'child' labour was commonplace.



What do you think a 'child' is? Have a go at your own definition, basing it on your own experience of being a child, perhaps a parent or sibling, and a nurse.

Your notes

Paediatric Nursing

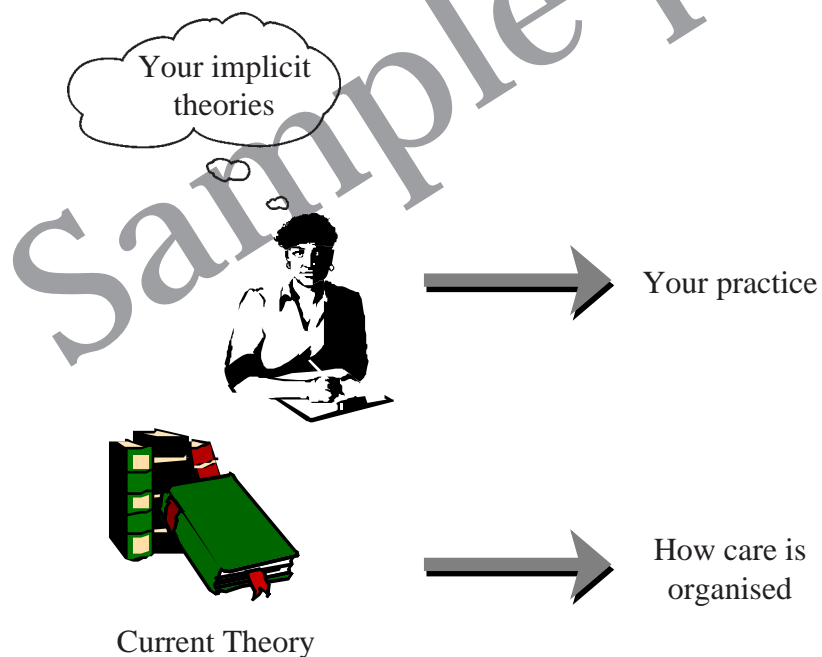
How different do you think your description is from that of someone living in the nineteenth century? Or perhaps the eighteenth century?

We now view 'adolescents' as an important part of our client group, often with their own special needs; different from adults and sometimes different from those of 'children'.

To what extent do you think the way we view children influences the way we organise their care? To create a branch of medicine called *paediatrics*, and a branch of nursing specialism in children's care, suggest that as a society we see children as being so important to us that it is worth such specialisation.

As we have already discussed in the core of this pack, the way we view our world affects how we behave towards it. Our implicit *theories-in-use* guide our practice.

It is vital for you, as a professional children's nurse, to understand the relationship between your own 'implicit theories of child development' and the generally held views in the literature; and to appreciate how these affect both your own approach to your practice, and the way in which we organise care for children and adolescents.



And your practice operates within a framework of care organisation, influenced by current theories.

So what are your implicit theories? How do you view children and their health care?

CHILD PROTECTION

What do you do?

You've got a ten year old there in front of you right now. Having noticed unusual bruising in the genital area, you asked her mother about it, who dismisses it as the result of a fall. You are suspicious. What do you do? What can you do? What are you expected to do? Should you interrogate the child? Inform someone else? Or assume it's nothing to worry about? What principles can guide your decision? (Remember: doing nothing is a decision with consequences).

"Child maltreatment has been recognised as a major public health problem the world over and is now reported to be among the top five causes of mortality in young children."

(Powell, 1997)

So what has it got to do with you?

"Children's nurses practising in all child health care settings are likely to meet child protection issues in the course of their work."





(Powell, 1997)

Basically, we feel that you need to know:




- what is involved in child abuse
- the implications of the Children's Act
- the implications for your practice

CHILD ABUSE

According to NSPCC (Powell 1997), this week three or four children will die at the hands of their carers or parents ...

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2 	3	4 	5 	6	7 	8

... and three or four will be disabled for life.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
2	3 	4	5 	6 	7	8

Paediatric Nursing

Child protection has been defined as:

"the promotion of decisive action to protect children from abuse and neglect."

(Powell, 1997)

The problem has been, in the past, whose action should it be? Government reports into the deaths of children at the hands of their parents have suggested that sharing information between agencies such as health, social services, the police, NSPCC and education might have prevented such occurrences.

Once report (*Working together*, 1988) points out that health care agencies have a major role in protecting children from abuse and neglect and in working with other agencies. The *Working Together* (1988) guidelines urge us to take a pro-active rather than reactive approach to abuse. In other words, once you have discovered that abuse has taken place, that is too late. Abuse usually takes place in a context over a period of time, and pro-active action can perhaps prevent more serious abuse before it occurs.

Powell (1997) suggests that:

"Child abuse consists of anything which individuals, institutions or processes do or fail to do which directly or indirectly harms children or damages their prospects of safe and healthy development into adulthood."

One reason why professionals are loath to take action is because of the high-profile cases where the action taken has itself caused trauma for the children concerned:

"Child protection processes may in themselves be damaging to children and families."

(Powell, 1997)

Abuse can include:

- Physical injury
- Neglect
- Emotional (or Psychological) Abuse including:
 - rejection
 - isolating
 - terrorising
 - ignoring
 - corrupting
- Sexual Abuse:

incest
paedophilia
exhibitionism
molestation
sexual intercourse
rape
sexual sadism
child pornography
child prostitution

THE EFFECTS OF ABUSE

People who are abused suffer short and long-term effects from their experiences, including dissociation, depression, low self-esteem, self harm and others.

There does not seem to be one widely-accepted model which can explain these effects, though there are many theories about the individual effects.

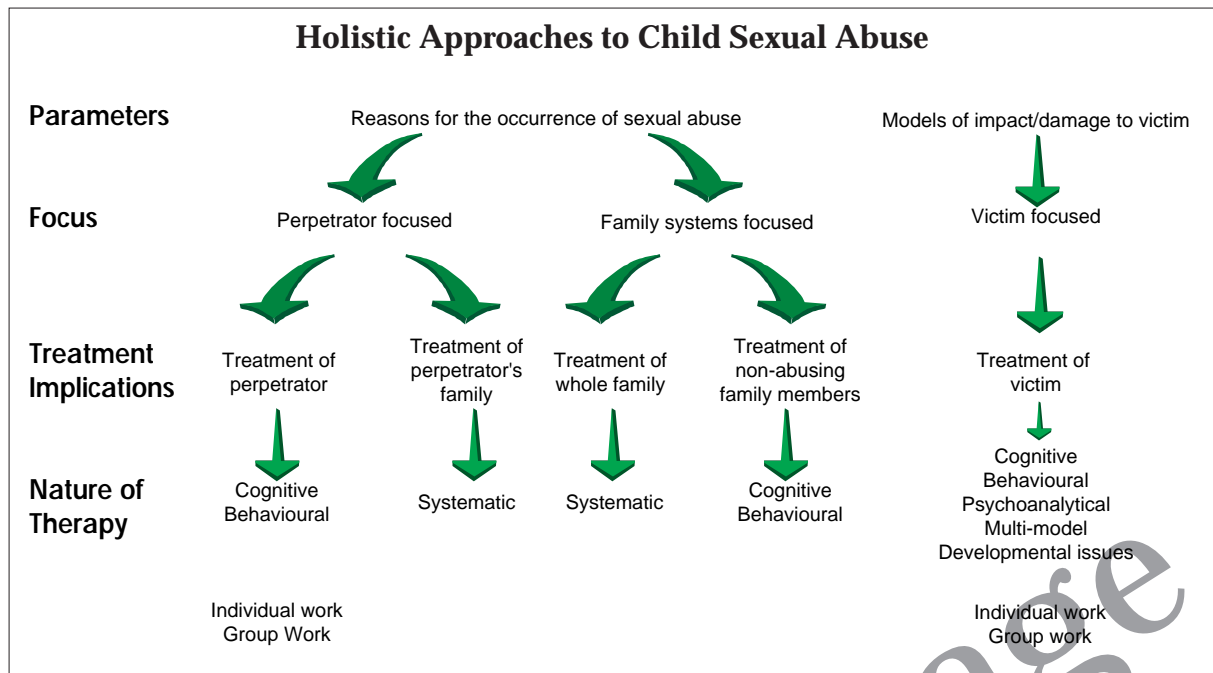
Finkelhor & Brown (1991) suggest four 'traumagenics' to help us to understand the effects of childhood sexual abuse. These are:

- **traumatic sexualisation:** the way a child's sexuality (feelings and attitudes) are shaped in a developmentally inappropriate and interpersonally dysfunctional manner as a result of sexual abuse.
- **betrayal:** refers to children's realisation that someone they depend on has caused them harm.
- **powerlessness:** the dynamic of being rendered powerless in which the child's will, desires and sense of efficacy are contravened.
- **stigmatisation:** negative feelings such as shame, guilt, badness.

These 'traumagenics' are not necessarily unique to sexual abuse, but can be considered to be the main effects following any trauma.

ASSESSMENT

Working with the victims of abuse is but one facet of dealing with the problems it creates. As the following diagram acts as a 'map' of the whole field, and gives you some insight into all that is involved.



Behavioural signs of sexual abuse depend on the child's age, sex and stage of development. As a generalisation:

Pre-school children: show direct physical responses - sexualisation of behaviour and regressive signs and symptoms.

School-age children: show schooling failures, loss of self-esteem patterns.

Adolescents: overdosing, running away, self-mutilation patterns, pregnancy, promiscuity, sexual abuse of other children, regression, anorexia.

Adults with delayed responses: sexual inhibitions and failures, parenting difficulties, physical abuse, pervasive loss of self-esteem.

Typical behavioural signs include:

- child hints at sexual activity through words, play or drawings
- family *secrets*, puzzling things at home - child is fearful of intervention

nb: sex education classes may lead some children to question what has been happening to them over a period of years

- child who is excessively preoccupied with sexual matters and who has detailed knowledge of adult sexual behaviour
- age-inappropriate sexual play with toys, other children or themselves
- excessive public masturbation
- child who has learnt to be sexually provocative to adults
- sudden, unexplained onset of bed-wetting and/or soiling. Regressive behaviour