Guidance on the use of this competency booklet.

How have the competencies been developed?
In response to thorough service analysis by different clinical areas a set of individual tasks have been identified and then risk assessed which together make up the role expected of a band 2 or a band 3 support worker within the trust.
A competency document has then been developed for each of these tasks (or in some cases the existing trust mandatory competencies will be used). The competencies have been written using the current evidence available to ensure best practice is delivered across the trust.

How are the competencies used?
The competencies are to be completed by the support workers after they have attended the Band 2 or Band 3 Clinical support worker skills workshop study days delivered by the clinical skills team along with some of the clinical nurse educators and nurse specialists. For the support worker to be deemed competent in the given skill they will have been taught about the task, thinking about the reasons behind why it is being done, any possible implications of carrying out the task and be aware of when to halt the procedure. They will then have the opportunity to practice the skill in a simulation environment before demonstrating the skill in a clinical setting with the supervision of a competent assessor who can decide that the support worker is in fact competent.

Who are the competencies for?
The competencies have been written so that they can be used as a resource by any member of staff who would need to carry out the skill. However for the staff member to be deemed competent in the skill they would need to have undergone the full process as described above.

Where can they be accessed?
The clinical support workers who have undertaken the study days have been issued with their own copy of the relevant competency book which is theirs to keep. Currently the competencies are held by the Calderdale Framework facilitators who can be contacted via the email Calderdale-facilitator@sch.nhs.uk. In the longer term the hope is that they will be available for staff to access as required by groups such as the clinical nurse educators and that the collection of competencies can serve as a resource for all bands of staff.

Who can assess?
For ease during the current pilot project support workers can be assessed by the clinical nurse educator or Calderdale facilitator in their area.

Once the project has been rolled out to all areas support workers can be assessed by any member of clinical staff who holds a teaching and assessing qualification and who is familiar with the content of the current competencies.

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INTRODUCTION

Welcome to your Support Worker competency booklet.

This booklet has been developed using the Calderdale Framework. The framework provides a clear and systematic method of reviewing skill mix and roles within a service to ensure quality and safety for patients. It has been developed using a seven stage process, which looks at the service provision and the best utilisation of the workforce to deliver that care.

The aim of the process is to ensure that the tasks are being done by the RIGHT PERSON in the RIGHT PLACE at the RIGHT TIME in the RIGHT WAY.

We have aimed to standardise the way that Support Workers across the Sheffield Children's Hospital are trained to ensure that the care that you are delivering to our patients are based on current and best evidence available.

This book, along with the taught sessions that you have attended, will allow you to practice the skills that are expected of you in your role as a Support Worker and demonstrate your competency in these skills. The expectation is that you will work to complete these competencies alongside the assessors in your clinical area who will sign you off as competent once the appropriate standard is reached.

It is intended that ward specific or future competency packages, gained through career progression, can be kept alongside this document in a portfolio, as ongoing evidence of your development and career at Sheffield Children's Hospital.
PATIENT ASSESSMENT-
TEMPERATURE RECORDING

Aim

- To correctly measure an infant’s/child’s temperature as part of an accurate assessment if the child’s condition. Recognising the importance of identifying any abnormal measurement, and responding accordingly.

Precautions

- Temperature should be taken if the child feels warm to touch (even if it was normal a short time before).
- Temperature should be taken if the child feels cold or if their skin looks mottled.
- Mercury thermometers should not be used
- The thermometer should be left in position long enough to gain an accurate reading (as per manufacturer’s instructions).
- Consider child’s condition and whether mobility allows for axillary recording.
- Avoid tympanic temperature recording if suspected or confirmed ear infections.

When to stop

If the child’s condition has deteriorated and requires prompt attention STOP and inform the child’s nurse.

Equipment

Dependent on child’s age

- Infants under 4 weeks – use electronic thermometer under axilla
- Infants and children 4 weeks to 5 years – use infra red tympanic thermometer or electronic/chemical dot thermometer under axilla
- Disinfectant Wipes

Procedure

1. Identify the appropriate timescale for undertaking the measurement as documented in the infant’s/child’s PEWS Chart. Also note precautions above for additional indications for measuring temperature

2. Seek consent to record the required observations from child/parent/carer (if available) explaining why it is important
3. Explain the procedure for the observations as you are carrying them out to the child using age appropriate language.

4. Clean your hands in accordance with the hospital infection control protocol.

5. Ensure the child is in a comfortable, rested position in the bed or chair while equipment is gathered.

6. Ensure all equipment is clean to infection control standards as described in local protocols and is in full working order.

7. (a) Infants under 4 weeks: Switch the thermometer on and place the tip of the probe under the axilla. Gently hold the infant's arm to keep the thermometer in place. Keep thermometer in place until it beeps to indicate a stable reading.
   (b) Infants and Children 4 weeks to 5 years: If using an axillary thermometer use as above. If using the tympanic thermometer, place disposable cover over the probe, gently pull the child’s ear straight back and place the probe in child’s ear canal (do not push or force this). Ask the child to keep their head still or gently hold their head. Press and hold the button until the machine beeps. Note the temperature reading.
   (C) Children 5 and above: Use axillary or tympanic thermometers as above. Or use oral route by ensuring the child has not had anything hot or cold for 20 minutes. Assess cooperation of the child, do not do if uncooperative, comatose, seizure prone or had recent oral surgery. Place disposable cover over the probe. Position under the child’s tongue, keep thermometer in place until it beeps, and then remove from mouth.

8. Clean the probe in line with infection control protocol

9. Document the temperature accurately on the PEWS Chart ensuring that time and date are also accurately and clearly recorded and complete the PEWS chart.

10. Inform a registered nurse immediately if the child is hypothermic < 36°C or hyperthermic >38°C

References

1. Standards for assessing, measuring and monitoring vital signs in infants, children and young people. 2013, RCN
### Patient Assessment - Temperature Recording

<table>
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| 1 | Identify the appropriate timescale for undertaking the measurement:  
Eg 1 hourly or post-operative observations  
Or if child feels warm, cold or has mottled appearance to skin. | DATE | DATE |
| 2 | Obtain consent to carry out the procedure from child/parent/carer (if available) | DATE | DATE |
| 3 | Give appropriate explanation of the procedure to the child/parent/carer answering any questions within own sphere of competence. Refer any questions outside of your responsibility to an appropriate member of the care team. | DATE | DATE |
| 4 | Ensure the infant/child is in a comfortable and appropriate position, removing any clothing necessary to facilitate the correct recording. | DATE | DATE |
| 5 | Collect the equipment required ensuring electrical equipment is fully charged and working correctly. Ensure it is clean in accordance with infection control policy prior to use. | DATE | DATE |
| 6 | Use the correct techniques to obtain an accurate measurement, ensuring you fit any equipment to the patient correctly. Observe the patient throughout, reporting any cause for concern to an appropriate member of the care team. | DATE | DATE |
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**Date of Review**
PATIENT ASSESSMENT - HEART RATE/ PULSE RECORDING

Aim

- To correctly measure an infant’s/child’s heart rate/pulse as part of an accurate calculation of Paediatric Early Warning Score (PEWS). Recognising the importance of identifying any abnormal measurement and escalating in line with PEWS guidelines.

Precautions

- Electronic data should be cross checked (by palpation or auscultation).¹
- When using electronic measurement ensure electrodes and leads are changed regularly (minimises risk of damage to skin).¹

When to stop

- If you cannot obtain a pulse (brachial or radial) on either arm STOP and inform a registered nurse immediately. Or pull buzzer if there is no sign of life.
- If the pulse is too fast to count or feels irregular STOP and inform a registered nurse.

Equipment

Dependent on setting:

- In PCCU heart rate is displayed on monitor
- Infants (under 2yrs) – require stethoscope to auscultate apex beat.
- Fob watch/ Clock with second hand in sight
- Disinfectant Wipes

Procedure

11. Identify the appropriate timescale for undertaking the measurement as documented on PEWS Chart.

12. Seek consent from the child/parent/carer (if available) to record the required observations, explaining why it is important.

13. Explain the procedure for the observations as you are carrying them out in age appropriate language for the child.

14. Clean your hands in accordance with the hospital infection control guidelines.

15. Ensure the infant/child is in a comfortable position in the bed or chair while equipment is gathered and clothing is moved to allow access to the radial or brachial pulse and/or apex beat.

16. Ensure the infant/child is comfortable, calm and as rested as possible, and the arm used for taking the pulse is comfortable and supported.
17. Ensure all equipment is clean to infection control standards as described in local guidelines.

18. (a) Children over 2 years: Locate a brachial/ radial pulse ensuring the arm used is supported on the bed or on a pillow using your index and middle fingers over the artery. Count the pulse for 60 seconds referring to the fob watch or clock. Note the palpated pulse should match that of the apex beat¹.

(b) Infants (under 2 years): Locate the apex beat of the heart (4-5 intercostal space/ Mid Clavicular Line) using the stethoscope. Count the heart rate for 60 seconds.

19. Document heart rate accurately on the PEWS Chart; ensure that the time and date are clearly recorded.

20. Complete a full set of observations in accordance with the protocol and escalate a response in accordance to the PEWS algorithm.

21. Electronic – Collect equipment and ensure it is in good working order. Place 2 electrodes above the level of the heart. One on the right side of the heart, the other on the left near the shoulder. The third lead should be placed below the heart on the left near the diaphragm. Ensure leads are connected correctly to the monitor as per the manufactures guidelines. Ensure the child is at rest, plus a clear trace is displayed on the screen, remove electrodes once they are not required or replace every 24 hours.

References

1. Standards of assessing, measuring and monitoring vital signs in infants, children and young people. 2013 RCN


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1. Identify the appropriate timescale for undertaking the measurement: 
   Eg 1 hourly or post-operative observations.

3. Obtain consent to carry out the procedure. Age appropriate explanation of the procedure answering any questions within own sphere of competence. Refer any questions outside of your responsibility to an appropriate member of the care team.

5. Ensure the infant/child is in a comfortable and appropriate position, removing any clothing necessary to facilitate the correct recording.

6. Collect the equipment required (fob watch or in clear sight of clock with second hand), stethoscope.

8. i) Use the correct techniques to obtain an accurate measurement, wrist (radial) or at elbow (brachial) using index and middle fingers.  
   ii) For infants locate the apex beat and using the stethoscope.  
   iii) Show understanding of when to use either technique.


10. Document the result clearly as part of the child’s PEWs score and accurately ensure the date and time are legible.

11. Recognise and report any measurement which falls outside normal levels. Escalate any abnormal readings as per PEWS guidelines.

12. Appropriate attitudes and behaviours displayed throughout.

Sign and date when achieved

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Date of Review
PATIENT ASSESSMENT - RESPIRATION RECORDING

Aim

- To correctly measure an infant's/child’s respirations as part of an accurate calculation of the Paediatric Early Warning Score (PEWS). Recognising the importance of identifying any abnormal measurement, promptly implementing the early warning algorithm in line with the PEWS.

Precautions

- It is important to note the effort and pattern of breathing as well as rate.
- Children under 7 years are abdominal breathers, therefore it is important to count abdominal movements.
- In cases where oxygen saturation monitoring is ongoing measure respirations simultaneously with this.

When to Stop

- If you are unable to obtain a respiratory rate STOP and inform a registered nurse immediately.
- If the child's colour is abnormal or is showing increased respiratory distress STOP inform a registered nurse.

Equipment

- Fob watch or sight of a clock with a second hand.

Procedure

22. Identify the appropriate timescale for undertaking the measurement as documented in PEWS Chart.

23. Seek consent to record the observations from parent/carer (if available) explaining why it is important.

24. Clean your hands in accordance with the hospital infection control protocol.

25. Be aware that if you inform the child that you are counting the respiratory rate, it can affect their rate of breathing. Ideally count the respiratory rate just before or just after counting the heart rate while holding the wrist.

26. Ensure the infant/child is in a comfortable, rested position in the bed or chair.

27. Observe the infant/child for colour, signs of cyanosis, pallor, mottling.
28. a) For infants and young children- place hand gently below the diaphragm.  
b) For older children- observe.

8. Count the respiratory rate for one full minute noting pattern and effort of 
breathing. Also note any signs of respiratory distress e.g. nasal flaring, 
grunting, stridor, use of accessory muscles and intercostal muscles.

29. Clean your hands in line with hospital infection control policy.

30. Document accurately the rate of breaths and the level of respiratory 
distress on the PEWS chart as part of the calculation of the PEWS score.  
Ensure the date and time is accurate and legible.

31. Escalate a response where necessary in accordance with the PEWS 
algorithm.

References

   Street Hospital Manual of Children’s Nursing Practice Wiley 
   Blackwell

   For Nursing Children & Young People. Holder Arnold Ltd
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<td>5  Observe the infant/child for colour, pallor, mottling, signs of cyanosis, pattern of breathing noting any use of accessory or intercostal muscles and any signs of distress</td>
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<td>Date of Review</td>
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PATIENT ASSESSMENT - OXYGEN SATURATION RECORDING

Aim

- To correctly measure an infant’s/child’s oxygen saturation levels as part of an accurate calculation of their Paediatric Early Warning Score (PEWS). Recognising the importance of identifying any abnormal measurement, and promptly implementing the early warning algorithm in line with PEWS.

Precautions

- The limb needs to be warm plus well perfused. Avoid areas of broken skin
- Any nail varnish should be removed as it can affect the reading.
- If reading taken simultaneously with BP measurement, a finger on the opposite hand must be used.
- In cases where the child’s normal oxygen saturation is outside normal acceptable limits this should be clearly documented by the medical and nursing staff.

When to stop

- If the pulse oximeter cannot record a saturation measurement and you are confident the machine is in full working order, **STOP** and inform a qualified nurse.

Equipment

- Pulse Oximeter or blood pressure machine with built in pulse oximeter.
- Appropriate sized probe (consider using reusable probe)
- Disinfectant Wipes

Procedure

32. Identify the appropriate timescale for undertaking the measurement as documented on the PEWS Chart.

33. Seek consent from child/parent/carer (if available) to record the required observations explaining why it is important.

34. Explain the procedure for the observations as you are carrying them out.

35. Clean your hands in accordance with the hospital infection control guideline.
36. Ensure the infant/child is in a comfortable, rested position in the bed or chair while equipment is gathered. Ensure probe is age or weight appropriate.

37. Ensure all equipment is clean to infection control standards as described in local protocols. Ensure the pulse oximetry light is working.

38. a) In infants/young children – apply to outer aspect of foot towards the base of the little toe or the big toe. Apply to the chosen fingertip or toe (thumbs should not be used).
b) Allow the probe time to settle and ensure the finger is still whilst the recording is taking place. This can take 30 to 60 seconds.
c) Check the strength gauge on the pulse oximetry equipment to ensure it is constant and at full power to be sure of obtaining an accurate reading.
d) If the child requires continuous monitoring leave the probe on and change the probe site at least 4 hourly. Set high and low alarm limits for pulse rate and oxygen saturations.

39. Clean hands and equipment as per hospital infection control guideline.

40. Document the percentage saturations accurately on the PEWS chart. Ensure the date and time is accurate and legible.

41. Escalate response to the early warning trigger in accordance with Trust protocol.

References


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<td>ii. Four hourly</td>
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<td>iii. Twice daily</td>
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<td>Wash hands or use alcohol gel before procedure in accordance with infection control guidelines</td>
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<td>Ensure infant/child is in a comfortable, rested and appropriate position, removing any clothing necessary to facilitate the correct recording.</td>
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<td>6</td>
<td>Collect the equipment required, ensuring electrical equipment is fully charged and working correctly. Ensure it is clean in accordance with infection control policy.</td>
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<td>7</td>
<td>Use the correct techniques to obtain an accurate measurement.</td>
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<td>9</td>
<td>Clean equipment as per infection control policy after use.</td>
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<td>10</td>
<td>Document the result clearly and accurately ensuring the date and times are legible.</td>
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<td>11</td>
<td>Ensure the early warning score is clearly documented and accurate and actioned accordingly. Recognise and report immediately any score which requires escalation</td>
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<td>12</td>
<td>Appropriate attitudes and behaviours reported throughout</td>
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- Signature of Learner
- Signature of Assessor

Date of Review
PATIENT ASSESSMENT-
NON INVASIVE BLOOD PRESSURE RECORDING

Aim

To correctly measure an infant's/child's blood pressure as part of an accurate calculation of their Paediatric Early Warning Score (PEWS). Recognising the importance of identifying any abnormal measurement, promptly implementing the early warning algorithm in line with PEWS.

Precautions

- Avoid using arms with IV infusions attached, and be aware of any injuries/infections to the arms. If both arms are affected, seek advice from a senior member of staff.
- Legs can be used.

When to stop

If a reading cannot be obtained STOP and inform a registered nurse – a manual and/or Doppler reading may be needed.

Equipment

- Portable electronic sphygmomanometer (e.g. Dinamap or Phillips)
- Correct sized cuff circumference of the upper arm - 2/3rds the length from shoulder to elbow and the internal bladder should encompass 90-100% of their arm.
- Correct sized cuff circumference of the calf -

Procedure

1. Identify the appropriate timescale for undertaking the measurement as documented in the PEWS Chart.
2. Explain the procedure to child/parent/carer and gain consent to continue, explain why it is important.
3. Clean your hands in accordance with the hospital infection control guideline.
4. Ensure the child is rested and comfortable on the bed or chair (for 3-5 minutes ideally) while the equipment is being gathered. Remove
any clothing or roll up the sleeve to clear the upper arm, and position the arm level with the heart.

5. Explain what you are doing in age appropriate language to the child.

6. Ensure all equipment is clean in accordance with the hospital infection control guidelines. Ensure the electronic sphygmomanometer is fully charged and turn power on to allow time for it to self-test or initialize.

7. a) Wrap the correctly sized cuff around the right arm (ideally) with the artery marker in line with the brachial pulse just above the elbow joint.
   b) Set the maximum pressure limit to 20 mmHg above the patient’s known systolic reading by using the Menu button on the electronic sphygmomanometer. If the reading is being taken for the first time, use the formula of Age x 2 plus 80 to estimate the Systolic & set the maximum pressure 20 mmHg above that.
   c) Start a pressure reading and allow it to complete the recording process. Keep the arm still.

8. Remove the cuff and clean in line with infection control protocol. Clean hands as per hospital infection control guideline.

9. Document clearly and accurately the blood pressure using X or an interrupted line between systolic and diastolic pressures, on the PEWS Chart.

10. Escalate response to the early warning trigger in accordance with Trust protocol.

References

1. Non Invasive Blood Pressure recording GOSH
   http://www.gosh.nhs.uk/health-professionals/clinical-guidelines/blood-pressure-monitoring/


**Patient Assessment - Non Invasive Blood Pressure**

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<th>TAUGHT</th>
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</table>
| 1 | Identify the appropriate timescale for undertaking the measurement:  
  v.   Hourly  
  vi.  Four hourly  
  vii. Twice daily  
  viii. On return from theatre/post procedure. | DATE & SIGN | DATE & SIGN | DATE & SIGN |
| 2 | Explain the procedure to child/parent/carer and obtain consent to carry out the procedure. | | | |
| 3 | Ensure the child is comfortable in bed or on a chair and an appropriate explanation of the procedure is given to the child. | | | |
| 4 | Wash hands or use alcohol gel before and after procedure in accordance with the hospital infection control guideline. | | | |
| 5 | Collect the equipment required ensuring electrical equipment is fully charged and is working correctly. Ensure it is clean in accordance with the hospital infection control guideline. | | | |
| 6 | Use the correct technique to obtain an accurate measurement, ensuring you fit the equipment to the patient correctly. | | | |
| 7 | Report any cause for concern to a registered nurse. | | | |
| 8 | Clean any equipment after use in accordance with the hospital infection control guideline. | | | |
| 9 | Document the result clearly and accurately ensuring the date and time is legible. | | | |

**Sign and date when achieved**

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PATIENT ASSESSMENT - WEIGHT RECORDING

Aim

- To obtain an accurate recording of an infant or child’s weight on admission and at least weekly thereafter, using equipment appropriate to the child’s age, developments level or mobility.
- To ensure medication is prescribed in the correct dose for that infant or child.
- Weight may also be recorded on a regular basis throughout the patient’s stay depending upon their medical condition or if initial assessment indicates the patient is underweight or obese as part of their ongoing care and monitoring.

Precautions

- If the patient has a prosthetic or medical device that cannot be removed, document on the weight chart.
- Ensure the scale is on a hard, flat surface and the display reads ‘0’.
- Infants under 2 years should be weighed unclothed and children over 2 years should be weighed without shoes and coats/thick clothing. Nappies should be removed.
- Infants and children over 2 years who can’t stand on the scale should be weighed whilst held by their parent/carer using the chair scale (Tared weighing)
- For infants under 4kg round down the last gram. For infants/children over 4kg round down to the last 100 grams.
- Consider the child’s condition and whether they can safely be weighed e.g. Osteogenesis Imperfect.

When to Stop

- If a patient has an adjunct (e.g. hip spica/cast etc.) STOP and discuss with a registered nurse before the weight taken.
- STOP if the patient has been diagnosed with an eating disorder as they should be weighed in growth and measurement.
- STOP if the patient will not stay still for accurate measurement and discuss with a registered nurse.

Equipment

- Scales of appropriate size

Procedure

1. Gather equipment and introduce yourself to the parent/carer and infant/child, check the infant/child’s identity and explain the procedure.
2. Wash hands as per hospital infection control guidelines.

3. (a) Tared Weighing- ask the parent/carer to remove their shoes and outdoor clothing and sit on the chair with their feet flat on the foot bar. Make a note of their weight rounding it to the nearest 0.1kg. Pass the infant/child to the parent/carer and allow the reading to settle. Subtract the parent/carer weight from the combined weight to obtain the infant/child’s weight.

(b) Pan scales – ensure the scales are clean then place a towel or soft paper into the pan scale. Gently lay the unclothed infant in the pan and allow him/her to settle before noting the reading.

(c) Chair scale - ask the child to remove any outdoor clothing/shoes/thick tops. The child sits in the chair with their back against the back rest and their feet on the foot bar. If the child cannot reach the foot bar use a smaller scale or use tared weighing. Allow the reading to stabilise then note the weight.

(d) Standing scale for over 2 years - the child should be minimally clothed and should stand with their feet slightly apart in the middle of the scale. Allow the reading to stabilise then note the weight.

(e) Hoist – position the child safely for hoisting ensuring the hoist scale is zeroed then attach the child and hoist, ensuring no contact points remain. Document weight ensuring with or without sling or clothing is specified.

4. Clean scales and wash hands as per infection control guideline.

5. Document the weight measurement and scale used. Inform nurse responsible for patient the new weight.

6. Repeat as directed. Ideally use the same scales otherwise inform the registered nurse if not available and document.

References


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<td><strong>Patient Assessment - Weight Recording</strong></td>
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<td><strong>1</strong></td>
<td>Gather equipment and introduce yourself to the parent/carer. Explain the procedure and gain consent.</td>
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<tr>
<td><strong>2</strong></td>
<td>Establish type of weighing required (Tared or direct scale) in order to obtain the measurement safely and accurately.</td>
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<tr>
<td><strong>3</strong></td>
<td>For Tared weighing ensure parent/carer has their removed shoes. Ensure the infant is unclothed apart from nappy. Ensure child has minimal clothing and have removed their shoes. For pan scale weighing ensure the scale is clean and a towel or soft paper is placed in the pan. For hoist weighing ensure the correct sling is selected.</td>
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<td><strong>4</strong></td>
<td>Allow the reading to stabilise before noting the measurement correctly in metric values. For Tared weighing note the parent/carer weight first, then the combined weight with infant/child.</td>
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<td><strong>5</strong></td>
<td>Document the measurement on the appropriate chart and in the nursing notes. Report any cause for concern to a registered nurse immediately.</td>
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<td><strong>6</strong></td>
<td>Repeat as directed/condition dictates.</td>
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**Sign and date when achieved**

- Signature of Learner
- Signature of Assessor
- Date of Review
PATIENT ASSESSMENT
RECORDING LENGTH/HEIGHT

Aim
To obtain an accurate recording of an infant or child’s height on admission.

Precautions
Infants (under 2 years) have length measured.

When to Stop
- If child is uncooperative or combative STOP and ask for help from a registered nurse.
- If equipment is faulty STOP and report to a registered nurse.
- If measurement is outside of normal parameters STOP and inform a registered nurse.

Equipment
- Measuring device (length board or height board)

Procedure
1. Introduce yourself to the child/parent/carer and explain the procedure. Confirm the infant/child’s identity and gain consent to continue.

2. Wash hands as per Infection Control Guidelines.

3. Collect equipment remove hats, hair decorations, shoes and nappy.

4. a) Length measurement – cover the board with cloth or soft paper. Ask parent/carer to place the infant on their back on the length board with their head in midline against the headboard (hair should be compressed). Hold the infant’s legs straight with one hand on the knees and adjust the foot board until in contact with the soles of their feet (making sure the infant is lying flat and straight). Record the length (to nearest millimetre).

b) Height measurement – Place the height board on level ground (or secured to wall). Stand the child straight with heels, buttocks, shoulder blades and back of head in contact with the vertical board/wall. Position the child’s head facing forward and so the tragus of the ear and corner of the eye are horizontal. Adjust the headboard to rest firmly on top of the child’s head (compressing the hair). Record the height (to nearest 1mm).
5. Wash hands and clean equipment as per Infection Control Guidelines.

6. Document the height measurement on the correct documentation.

References

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<td><strong>PATIENT ASSESSMENT- RECORDING HEIGHT/LENGTH</strong></td>
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<td>Gather equipment</td>
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<td></td>
<td>Introduce yourself, explain the procedure and gain consent.</td>
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<td>2</td>
<td>Identify which style of measurement is to be carried out.</td>
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<td>3</td>
<td>Ensure child is appropriately clothed.</td>
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<td>4</td>
<td>Carry out the measurement correctly in metric values.</td>
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<td>5</td>
<td>Document the measurement on the appropriate chart and in the nursing notes. Report any cause for concern to a senior member of staff immediately.</td>
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<td>6</td>
<td>Carries out procedure as per Infection Control Guidelines.</td>
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PATIENT ASSESSMENT
PAIN ASSESSMENT

Aim

- To recognise, assess and record pain scores of any child experiencing acute pain, long term pain and those undergoing procedures.
- To ensure that appropriate pain management strategies are adapted and that relevant information is passed on to the registered nurse responsible for the child.

Precautions

- Pain is difficult to measure accurately and reliably in children and there is no one single method of pain assessment that has been validated for children of all ages.
- SCH Paediatric Pain Scale Documentation allows pain to be scored either by self-report or behavioural assessment.
- Ensure appropriate pain assessment tool is used
  - Numerical rating scale
  - Faces scale
  - FLACC scale

When to stop

- If the child is displaying signs of immediate pain STOP and inform a senior member of staff.

Equipment

- SCH (NHS) Foundation Trust Pain Assessment Tool

Procedure

1. Check with a registered nurse that it is appropriate to undertake a pain score assessment. All children have pain assessment as part of the PEWS observations.

2. Introduce yourself to the patient. Explain that you are going to assess their level of pain to ensure they are receiving appropriate pain relief and to monitor the effectiveness of that pain relief.
3. Show the parent and child the Trust’s patient assessment tool, select the correct tool for the child’s age/ability/condition or the one previously used for consistency.

4. Observe the child’s behaviour and physiological signs. Report any relevant information to the registered nurse responsible for the child.

5. Involve the parent(s)/carer where appropriate

6. Document the pain score in the appropriate section of the PEWS chart or on the pain infusion chart and inform the registered nurse responsible for the child.

References


2. Macqueen S -- The Great Ormond Street Hospital Manual of Children’s Nursing Practice Chapter 21 pages 539 – 548

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<th>NAME:</th>
<th>TAUGHT</th>
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<td><strong>PHYSIOLOGICAL MEASUREMENT – PAIN ASSESSMENT</strong></td>
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<td>1</td>
<td>Check with a senior member of the team it is appropriate to undertake a pain score assessment.</td>
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<td>2</td>
<td>Introduce yourself to the patient and explain you are going to assess their level of pain.</td>
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<td>3</td>
<td>Check with a qualified nurse if analgesia has been given and when.</td>
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<td>4</td>
<td>If appropriate to plan of care, carry our physiological measurements as per competency.</td>
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<td>5</td>
<td>Ask the patient to score their pain using the phrase ‘What would you score your pain, 0 being no pain at all and 10 being the worst pain you have ever experience?’</td>
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<td>6</td>
<td>Ask the patient to rate their pain in this way for both at rest and on movement.</td>
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<td>7</td>
<td>Ask the patient to describe their pain to you.</td>
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<tr>
<td>8</td>
<td>Ask the patient if they feel nauseous and/or have vomited. If yes notify a senior member of staff.</td>
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<td>9</td>
<td>Record the pain score on the appropriate documentation.</td>
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**Signature of Learner**

**Signature of Assessor**

**Date of Review**

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PERSONAL CARES -
ANTI-EMBOLISM STOCKINGS

Aim
To accurately size a patient for anti-embolism stockings and to fit them effectively.

Precautions
- Do not apply stockings if the skin is broken, infected, had leg surgery, phlebitis or has an intravenous cannula in situ.
- Check no contra indications on the back of the package.
- Ideally use thigh high stockings.

When to stop
- If the patient is uncooperative or showing signs of pain STOP and ask for help from a registered nurse.

Equipment
- Tape measure
- Paper and pen
- Sizing chart
- Anti-embolism stocking of the correct size

Procedure
1. Introduce yourself to the child/parent/carer. Give an explanation of the planned procedure and gain consent.
2. Collect tape measure, pen and paper to record the leg measurements.
3. Wash hands as per the infection control guideline.
4. Position the child in a comfortable position.
5. Measure the narrowest ankle circumference and determine the initial stocking size.
6. Measure the largest calf circumference. If the calf measurement indicates a larger size stocking than ankle measurement, select the larger stocking.
7. For thigh length stockings, measure the largest thigh circumference and measure the distance from the gluteal crease to the bottom of the heel.
8. For knee length, measure distance from the bend of the knee to the bottom of the heel.

9. Use sizing chart on packaging to establish the correct size stocking.

10. Insert hand into stocking as far as the heel pocket.

11. Grasp the centre of the heel pocket and turn the stocking inside out to the heel area.

12. Position the stocking over the foot and heel. Be sure the patient’s heel is centred in the heel pocket.

13. Pull a few inches of the stocking up around the ankle and calf.

14. Continue pulling the stocking up the leg.

15. For thigh length stockings, the top band should rest in the gluteal fold just below the buttock.

16. For knee length stockings, the top band should be 3-5cm below the bottom of the knee cap.

17. Smooth out all excess material. Pull toe section away from the toes using the inspection hole to smooth stocking and allow for toe comfort.

18. Wash hands as per infection control guideline. Discard any disposable equipment.

19. Ask patient to report any feeling of numbness, tingling, pain or discomfort.

20. Observe skin 2-3 times per day for discolouration, marking or blistering.

21. Document the style and size of the stocking in the nursing notes.

Reference

<table>
<thead>
<tr>
<th>NAME: Personal Cares - Anti-Embolism Stocking</th>
<th>TAUGHT</th>
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<tr>
<td>1. Check patient identity, give explanation of the procedure and gain consent.</td>
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<tr>
<td>2. Wash hands as per infection control guidelines.</td>
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<tr>
<td>3. Collect necessary equipment:</td>
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<tr>
<td>4. Ensure child/infants privacy and dignity is maintained.</td>
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<td>5. Correctly take leg measurements</td>
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<tr>
<td>6. Identify and collect the correct style and sized stocking</td>
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<td>7. Apply stocking correctly.</td>
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<td>8. Wash hands as per infection control guideline.</td>
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<tr>
<td>9. Encourage patient to report and numbness, tingling, pain or discomfort.</td>
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<tr>
<td>10. Check skin for discolouration, marking or blistering 2-3 times per day.</td>
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<td>11. Document cares carried out in the appropriate nursing documentation.</td>
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<tr>
<td>12. Appropriate attitudes and behaviours displayed throughout</td>
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PERSONAL CARES - ASSISTED BATH

Aim

- To maintain the child’s personal hygiene when they are unable to carry out their own cares fully without assistance, whilst promoting independence throughout.

Precautions

- Does the child have any wounds or attachments e.g. IV lines or oxygen which needs to be considered.

When to stop

- If the child’s condition deteriorates STOP the process and seek help immediately.

Equipment

- Toiletries (child’s own if they have them)
- Towels
- Clean nightwear / clothes
- Apron and gloves
- Trust approved detergent cleaning agent

Procedure

1. Introduce yourself to the child and parents. Explain you are going to provide assistance for them to have a bath. Check the child is happy to proceed and gain consent.

2. Wash and dry hands as per infection control guidelines.

3. Collect equipment, check with the child to see if they have their own toiletries and change of clothes / nightwear. If not use hospital supplies.

4. Go to the bathroom and run the bath checking the temperature (elbow tolerant).

5. Assist the child to the bathroom either mobilising or wheeling consistent with their plan of care. Ensure tracheostomy patients have emergency equipment and suction readily available.

6. Close the bathroom door and maintain privacy by ensuring a sign is displayed noting that the bathroom is in use.
7. Apply apron and gloves and assist the child to undress.

8. Using the appropriate bath aids, assist the child into the bath.

9. Place the toiletries within easy reach of the child and encourage independence with washing.

10. Offer assistance for difficult to reach parts such as the back and feet. Observe pressure areas throughout.

11. Ask the child if they would like you to stay or leave the room until they have finished. Ensure emergency buzzer is within reach before leaving the room.

12. When washing is completed, use the bath aids to assist the child out of the bath. Empty the bath water.

13. Provide assistance with towel drying and dressing according to child’s needs and abilities.

14. Offer the child the opportunity for hair brushing/combing providing support and assistance where needed.

15. Ensure that all their personal needs have been met.

16. Remove and dispose of gloves and apron and wash hands as per infection control guidelines.

17. Escort child back to their bed and ensure they are settled and comfortable in bed or a chair at the bedside.

18. Apply clean gloves and apron then return to bathroom. Clean bath using appropriate cleaning agent. Tidy away dirty linen.

19. Wash and dry hands as per infection control guidelines.

20. Record completion of task in appropriate documentation and feedback to the nurse in charge.

References


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<tr>
<th>PERSONAL CARES - ASSISTED BATH</th>
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<td>obtain their consent.</td>
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<td>2 Follow correct infection</td>
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<td>control guidelines and wash</td>
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<td>&amp; dry hands thoroughly.</td>
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<td>3 Collect the necessary</td>
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<td>4 Run the bath, checking</td>
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<td>the temperature carefully.</td>
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<td>5 Uses correct manual</td>
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<td>handling techniques and</td>
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<td>uses appropriate bath aids</td>
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<td>the water</td>
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<td>6 Maintains privacy and</td>
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<td>dignity throughout.</td>
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<td>7 Encourages independence</td>
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<td>with washing but offers</td>
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<td>and provides assistance</td>
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<td>8 Observe pressure areas</td>
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<td>9 Clean bath using trust</td>
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<td>approved detergent cleaning</td>
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<td>10 Disposes of linen into</td>
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<td>correct bags</td>
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<td>11 Record completion of task</td>
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Sign and date when achieved

**Signature of Learner**

**Signature of Assessor**

**Date of Review**
PERSONAL CARES - ASSISTED SHOWER

Aim

- To maintain the child’s personal hygiene when they are unable to carry out their own cares fully without assistance, whilst promoting independence throughout.

Precautions

- Is the child able to mobilise sufficiently to carry out the procedure.
- Does the child have any wounds or attachments e.g. IV lines which need to be considered.

When to stop

- If the child’s condition deteriorates STOP the process and seek help immediately.

Equipment

- Toiletries (patient’s own if they have them)
- Towels
- Clean nightwear / clothes
- Apron and gloves
- Trust approved detergent cleaning agent

Procedure

1. Introduce and explain you are going to provide assistance for them to have a shower. Check the parent/carer is happy to proceed and gain consent.

2. Wash and dry hands as per infection control guidelines.

3. Collect equipment, check with the child if they have their own toiletries and change of clothes / nightwear. If not use hospital supplies.

4. Assist the child to the bathroom either mobilising or wheeling them as per their plan of care.

5. Close the bathroom door and maintain privacy by ensuring a sign is displayed noting that the bathroom is in use.

6. Turn on shower to appropriate temperature (elbow tolerant) and ensure shower chair is available should it be required.
7. Apply apron and gloves and assist the child to undress.

8. Help the child into the shower and check with them that the temperature is comfortable. Carefully adjust as necessary.

9. Place the toiletries within easy reach of the child and encourage independence with washing.

10. Offer assistance for difficult to reach parts such as the back and feet. Observe pressure areas throughout.

11. Ask the child if they would like you to stay or leave the room until they have finished (ensure the emergency buzzer is within reach before leaving the room) if safe.

12. When washing is completed, turn off the shower and assist the child out.

13. Provide assistance with towel drying and dressing according to child’s needs and abilities.

14. Offer the child the opportunity for hair brushing/combing providing support and assistance where needed.

15. Check the child is happy that all their personal hygiene needs have been met.

16. Remove gloves and apron and wash and dry hands as per infection control guidelines.

17. Escort the child back to their bed and ensure they are settled and comfortable in bed or a chair at the bedside.

18. Apply clean gloves and apron and return to bathroom. Clean shower using trust approved detergent cleaning agent. Tidy away dirty linen.

19. Wash and dry hands as per infection control guidelines.

20. Record completion of task in appropriate documentation and inform the nurse in charge.

References

<table>
<thead>
<tr>
<th>NAME:</th>
<th>PERSONAL CARES – ASSISTED SHOWER.</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduce yourself, explain that you are going to assist them to shower and obtain their consent.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td>2</td>
<td>Follow correct infection control guidelines and wash &amp; dry hands thoroughly.</td>
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</tbody>
</table>
| 3     | Collect the necessary equipment:  
   i.  Towels  
   ii. Toiletries / Disposable cloths  
   iii. Disposable gloves & apron  
   iv.  Clean nightwear / clothes  
   v.  Trust approved detergent cleaning agent  
If patient doesn't have own toiletries use hospital supplies. | | | |
<p>| 4     | Assist the child to the bathroom either mobilising or wheeling consistent with their plan of care. | | | |
| 5     | Close the bathroom door and maintain privacy by displaying a bathroom in use sign. | | | |
| 6     | Turn on the shower to appropriate temperature (elbow tolerant) and ensure shower chair is available should it be needed. | | | |
| 7     | Apply apron and gloves and assist the child to undress as their needs dictate. | | | |
| 8     | Help the child into the shower and check the temperature is comfortable. Adjust as necessary. | | | |
| 9     | Place toiletries within easy reach of child and encourage independence with washing. | | | |
| 10    | Offer assistance for difficult to reach areas. Observe pressure areas throughout. | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>PERSONAL CARES – ASSISTED SHOWER</th>
<th>TAUGHT DATE &amp; SIGN</th>
<th>MODELLED DATE &amp;SIGN</th>
<th>COMPETENT DATE &amp;SIGN</th>
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<tr>
<td>11</td>
<td>Ask patient if they want you to stay or leave the room, ensure emergency buzzer is in easy reach for the patient before leaving the room.</td>
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<tr>
<td>12</td>
<td>When washing is complete, turn off the shower and assist the child out.</td>
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<tr>
<td>13</td>
<td>Provide assistance with towel drying and dressing according to child’s needs and abilities.</td>
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<td>14</td>
<td>Offer the child the opportunity for hair brushing/combing, provide assistance if necessary.</td>
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<tr>
<td>15</td>
<td>Check the child is happy their personal hygiene needs have been met.</td>
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<tr>
<td>16</td>
<td>Remove gloves and apron and wash and dry hands as per infection control guidelines.</td>
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<tr>
<td>17</td>
<td>Escort the child back to their bed and ensure they are settled and comfortable in bed or in a chair.</td>
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<tr>
<td>18</td>
<td>Apply clean gloves and apron and return to bathroom. Clean shower using trust approved detergent cleaning agent. Tidy away dirty linen.</td>
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<tr>
<td>19</td>
<td>Wash and dry hands as per infection control guidelines.</td>
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<td>20</td>
<td>Record completion of task in appropriate documentation and feedback to nurse in charge.</td>
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<tr>
<td>21</td>
<td>Appropriate attitudes and behaviours displayed throughout.</td>
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<td><strong>Sign and date when achieved</strong></td>
<td><strong>Signature of Learner</strong></td>
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<td><strong>Signature of Assessor</strong></td>
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PERSONAL CARE
BATHING AN INFANT

Aim

To safely and effectively bathe an infant to promote good hygiene and to maintain skin health and integrity

Precautions

- Consider the infant’s medical condition. Do they have any attachments such as oxygen, monitors, IV lines or feeding tubes? Do they have any skin conditions, wounds or allergies which could affect their ability to be bathed?
- Young infants become cold quickly so take care not to unnecessarily prolong the process.

When to stop

- If the child’s condition deteriorates **STOP** the process and seek help immediately.
- If you notice any redness, swelling or previously unknown wounds **STOP**, ensure the child is safe and warm and inform the child’s nurse.

Equipment

- Dry wipes or the child’s own wash cloth
- Baby bath
- Appropriate liquid cleanser or emollient (Discuss with the child’s nurse)
- Two towels
- Clean clothes
- Disposable apron and gloves
- Trust approved detergent cleaning agent
- Clean nappy
- Bath Thermometer

Procedure

21. To help ensure the child remains warm throughout the procedure close doors and windows where possible.

22. Wash hands and apply disposable apron and gloves.

23. Gather all equipment within easy reach.

24. Put cold water in the bath first and then add warm water to reach the required depth (5-8cm) and temperature.
25. If a bath thermometer is available the water should be 37°C, if not the water should be tested with the elbow and should feel warm, not hot or cold.

26. Undress the infant down to their nappy and swaddle them in a towel, leaving the head uncovered.

27. Wash the baby’s eyes, ears, face and neck.

28. Hold the baby so the head is over bath water by laying them along your non-dominant forearm supporting their head on your hand.

29. Use disposable cloth or flannel to wet the hair. If using shampoo/liquid cleanser apply to the hair.

30. Rinse carefully then dry using a second towel so the baby is kept warm.

31. Remove the baby’s nappy and ensure they are clean.

32. Put your hand and arm around the back and shoulders holding the distant arm. Support the baby’s buttocks and place them into the bath feet first.

33. Keeping one hand under the head, back and shoulders wash the baby from top to bottom taking special care around the creases.

34. Rinse the baby before lifting them from the bath onto a dry towel.

35. Wrap the baby in a towel and pat them dry then put a clean nappy on.

36. Apply any necessary creams or emollients as discussed with the child’s nurse.

37. Dress the baby and return them to their cot.

38. Dispose of any waste in clinical waste bin and any used linen in linen skip.

39. Wash the bath out with hot soapy water or disinfectant wipes, dry it and return it to storage area.

References


<table>
<thead>
<tr>
<th></th>
<th>PERSONAL CARES – Bathing an infant</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Adhere to infection control guidelines throughout.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td>2</td>
<td>Ensure the patient is kept warm throughout the procedure.</td>
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<td>3</td>
<td>Gather necessary equipment.</td>
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<td>4</td>
<td>Uses appropriate depth and temperature of bath water.</td>
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<td>5</td>
<td>Cleans the infant’s hair before attending to nappy cares. Then cleans from top to bottom while the child is in the bath.</td>
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<tr>
<td>6</td>
<td>Correct handling of baby throughout.</td>
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<td>7</td>
<td>Disposal of waste and linen after procedure.</td>
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<tr>
<td>8</td>
<td>Cleaning and storage of equipment.</td>
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**Sign and date when achieved**

- Signature of Learner
- Signature of Assessor
- Date of Review
PERSONAL CARES
BED BATH AND HAIR WASH FOR THE DEPENDENT CHILD

Aim
To maintain a patient’s personal hygiene and dignity when they are unable to move from the bed, observing pressure areas and assisting where appropriate whilst promoting independence throughout.

Precautions
- Does the child have any wounds or attachments e.g. IV lines or oxygen which needs to be considered
- Request assistance/ as required or where available.
- Use Moving and Handling techniques and aids where appropriate.

When to stop
- If the child becomes distressed, refuses or you need more assistance STOP and seek help.

Equipment
- Clean bowl
- Jug
- Disposable gloves and apron
- Clean clothes/nightdress or theatre gown
- Patient’s own toiletries, towels.
- Bedding: 2 clean sheets, pillowcases, blanket.
- Linen skip - white bag for unsoiled linen, red alginate bag for soiled or infected linen.
- Hairdryer
- Manual handling aids as required.

Procedure
1. Introduce yourself to the child/parent/carer, checking identity, explain what you are going to do and gain consent.
2. Clear bed table to accommodate equipment.
3. Collect equipment, check with patient if they have their own toiletries and change of clothes / nightwear. If not use hospital supplies.
4. Ensure privacy by closing the curtains around the bed space and reduce any draughts by closing windows/doors.

5. Wash hands as per infection control guidelines. Apply apron and gloves.

6. Fill bowl with warm water, checking the temperature using elbow tolerance

7. Fold back the bedclothes and assist the patient to remove their clothing, covering them with the sheet or towels to maintain patient dignity at all times.

8. Wash the patient’s face and neck first, promoting independence. Rinse and towel dry.

9. Wash the patient’s hands and arms, rinse and dry with towel. Observe skin integrity, noting any red/sore areas. Lower sheet to hip area, ensuring genitals are covered with the sheet to maintain dignity.

10. Wash patient’s chest, abdomen and underarms with soapy water, rinse and dry with towel. Pay specific attention to creases and armpits. Observe skin integrity, noting any red/sore areas, informing a registered nurse if appropriate.

11. Re-cover patient with sheet up to neck and uncover legs.

12. Wash the patient’s legs and feet, rinse and dry with towel. Pay specific attention to heels and in-between toes. Observe skin integrity, noting any red/sore areas.

13. Ask the patient if they are able to wash their genitalia. If unable gain consent and assist where needed. Raise sheet to umbilical area exposing genitals.

14. (a) If physically able, encourage the patient to undertake this part of the procedure themselves.
   (b) If the patient is unable, wash, rinse and dry with towel.
      * In male patients clean under the foreskin.
      * In females clean front to back.
   Cover lower half of body with sheet.

15. If necessary ask a member of staff to roll patient exposing back and buttocks. Place a towel underneath patient. Wash from neck to buttocks, rinse and dry with a towel. Observe skin integrity, noting any red/sore areas. Roll onto back.

16. Using Moving and Handling techniques move the patient up the bed so that their head is on the edge of the mattress. Tuck the sheet under their shoulders. Empty the bowl.
17. Place the hair washing tray under the patient using the empty bowl as the receiver. Use a jug of warm water (checking temperature) to wet the patient's hair. Shampoo, rinse and dry with a towel, leaving a towel underneath their head.

18. Using Moving and Handling techniques move the patient down the bed.

19. Roll the patient onto their side. Roll the dirty sheet towards the patient. Place a clean. Place a clean sheet on the exposed mattress, ensuring there is enough to tuck in. Roll the clean sheet towards the patient. Roll the patient onto the opposite side over the roll. Remove the dirty sheet and roll the clean sheet out. Pull out the creases and tuck the sheet in.

20. Assist the patient to dress in clean clothes, asking for help as needed.

21. Remove dirty top sheet, apply clean sheet and blanket. Replace pillowcases. Place all dirty linen in white linen skips. If soiled with bodily fluids then a red alginate bag should be used.

22. Position patient comfortably (ideally sat up), ensuring the call button is reachable.

23. Brush patient’s hair, drying with a hairdryer if required.

24. Ensure bed rails are raised. Clean and tidy the bed space and equipment used. Dispose of all single use equipment in the correct clinical waste bin.

25. Remove gloves and apron and dispose of in the clinical waste bin. Wash hands as per infection control guidelines.

26. Document cares carried out, toileting and position of patient in the appropriate nursing documentation.

Reference

<table>
<thead>
<tr>
<th>NAME:</th>
<th>TEACH</th>
<th>MODEL</th>
<th>COMPETE</th>
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</thead>
<tbody>
<tr>
<td><strong>BED BATH AND HAIRWASHING FOR THE DEPENDENT CHILD</strong></td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td>1. Check patient identification, give an appropriate explanation of the task to the patient and obtain their consent.</td>
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<tr>
<td>2. Follow correct Infection Control Procedure and wash &amp; dry hands thoroughly (NU15).</td>
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<tr>
<td>3. Collect the necessary equipment:</td>
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<tr>
<td>4. Ensure the bedside area is private and that there are no draughts. Put on protective gloves and plastic apron.</td>
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<tr>
<td>5. Clear the bed table to accommodate washbowl and equipment.</td>
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<tr>
<td>6. Fill bowl with warm water, checking temperature.</td>
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<tr>
<td>7. Fold back the bedclothes and assist the patient to remove their clothes covering them with the sheet. If they have a drip or infusion ask a member of nursing staff for assistance.</td>
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<td>8. Wash and rinse the face and neck. Dry the area thoroughly.</td>
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<tr>
<td>9. Wash, rinse and dry hands and arms. Observe pressure areas.</td>
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<tr>
<td>10. Wash, rinse and dry the upper body. Observe pressure areas.</td>
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<td>11. Recover patient with sheet up to neck and uncover legs.</td>
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<tr>
<td>12. Wash, rinse and dry the legs. Observe pressure areas.</td>
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<tr>
<td>13. Inform the patient you are going to wash around the genitalia and obtain verbal consent, encouraging them to self-care if possible.</td>
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<td>14. If patient unable, wash, rinse and dry the area, cleaning appropriately.</td>
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<tr>
<td>15. Roll the patient onto their side – wash, rinse and dry back and buttocks. Observe pressure areas.</td>
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<tr>
<td>16</td>
<td>Use correct Moving and Handling techniques to move patient up the bed.</td>
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<td>17</td>
<td>Wash and rinse patient’s hair using the correct equipment.</td>
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<td>18</td>
<td>Move patient down the bed.</td>
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<td>19</td>
<td>Change the bottom sheet effectively.</td>
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<td>20</td>
<td>Help the patient dress. If they have attachments ask nursing staff for assistance.</td>
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<td>21</td>
<td>Remake the rest of the bed using clean linen. Dispose of used linen appropriately.</td>
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<tr>
<td>22</td>
<td>Assist the patient to reach a comfortable position. Place call buzzer in reach.</td>
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<tr>
<td>23</td>
<td>Brush / Comb and dry their hair.</td>
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<td>24</td>
<td>Leave the bed space clean and tidy, disposing of equipment as required.</td>
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<tr>
<td>25</td>
<td>Remove gloves and apron putting them in a clinical waste bin. Wash &amp; dry your hands thoroughly (NU15).</td>
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<tr>
<td>26</td>
<td>Document accurately in the patients notes the cares carried out</td>
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<td>27</td>
<td>Appropriate attitudes and behaviours displayed throughout</td>
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<tr>
<th>Sign and date when achieved</th>
<th>Signature of Learner</th>
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<td></td>
<td>Signature of Assessor</td>
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<td>Date of Review</td>
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PERSONAL CARES
ASSISTED TOILETING USING A COMMODE

Aim

To enable the patient who is unable to mobilise to the toilet to empty their bladder and/or evacuate their bowel whilst maintaining privacy and dignity throughout.

Precautions

- Standard infection control precautions must be followed throughout.
- Presence of drains, IV fluids, dressings etc.

When to stop

- If the child/infant is difficult to move STOP and report to a registered nurse.
- If the child is unable to pass urine and/or open bowels STOP and report to a registered nurse.
- If any unusual output is noted (e.g. loose stools) STOP and inform a registered nurse.

Equipment

- Manual Handling Plan
- Commode and inner pan (usually plastic bowl)
- Toilet tissue/Disposable wipes
- Soap, water, towel.
- Disposable gloves & aprons
- Disinfectant wipes

Procedure

1. Introduce yourself to the child/parent/carer; give explanation of the planned procedure. Gain patient consent.

2. Collect the necessary equipment.

3. Wash hands and apply gloves and apron in accordance with the hospital infection control guideline.

4. Ensure that the curtains/doors are closed around the child/infant to provide privacy and dignity.

5. Remove any clutter from the bed area to allow the transfer to take place safely. Place the commode at the bedside making sure all the brakes are on.
6. Provide the correct level of supervision/assistance to the child/infant, stand the child, transfer to the commode as directed in the manual handling plan and then remove their undergarments.

7. Leave the child if appropriate, and ensure that curtains/doors around the child are closed to maintain the patient’s privacy and dignity. Give the child the nurse call button and ensure they can use it. Ask them to ring when they need assistance, but inform them you will check back.

8. Remove gloves and apron, wash and dry hands.

9. When the child has finished on the commode, wash hands and apply gloves and apron before assisting with the child.

10. If the child is unable to clean themselves then ensure that they are clean using toilet tissue and disposable wipes, dispose of these into a clinical waste bag. Ensure that the child/infants clothing remains clean during this procedure and replace if not.

11. Provide the correct level of supervision/assistance to allow safe transfer from to the commode to bed/chair as directed in the manual handling plan.

12. Help to wash and dry the child’s hands using warm water, soap and a towel.

13. Ensure that the child/infant is comfortable and their dignity needs have been met before opening the curtains.

14. Cover the commode, remove the brakes then return the commode to the dirty utility room and dispose of the pan contents into the sluice. Wash the pan in the bedpan washer. Take note of contents.

15. Clean the commode as per infection control guideline. Apply “clean” sticker.

16. Remove gloves and apron and wash and dry hands.

17. Document and record the procedure in the nursing notes and fluid balance chart.

References

### PERSONAL CARES – ASSISTED TOILETING USING A COMMODE

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<th>TAUGHT</th>
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<th>COMPETENT</th>
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<tbody>
<tr>
<td>1</td>
<td>Check Manual Handling Plan to determine current levels of mobility.</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td>2</td>
<td>Give an explanation of the planned procedure, gain the child/infants consent.</td>
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<td>3</td>
<td>Follows the infection control guideline throughout the procedure.</td>
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<td>4</td>
<td>Promotes privacy and dignity.</td>
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<td>5</td>
<td>Provide the correct level of supervision/assistance to allow safe transfer onto and off of the commode as directed in the manual handling plan.</td>
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<td>6</td>
<td>Give the patient the call bell and explain how to use it. Ask them to press the buzzer when they require assistance but assure them you will make checks to ensure they are safe.</td>
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<td>7</td>
<td>If the patient is unable to clean themselves then ensure that they are clean. Help the patient to wash their hands after using the commode.</td>
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<td>8</td>
<td>Return the commode to the dirty utility room and dispose of the bedpan appropriately.</td>
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<td>9</td>
<td>Document result as appropriate in nursing notes/fluid balance chart/Bristol stool chart</td>
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<td>10</td>
<td>Appropriate attitudes and behaviours displayed throughout</td>
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**Sign and date when achieved**

- Signature of Learner
- Signature of Assessor
- Date of Review
PERSONAL CARES
ASSISTED TOILETING USING A SANI-CHAIR

Aim

To enable the child/infant who is unable to mobilise to the toilet to empty their bladder and/or evacuate the bowel whilst maintaining privacy and dignity throughout.

Precautions

- Standard infection control precautions must be followed throughout.
- Presence of drains dressings, frames etc.

When to stop

- If the child is difficult to move **STOP** and report to a registered nurse.
- If the child is unable to pass urine and/or open bowels **STOP** and report to a registered nurse.
- If any unusual output is noted (e.g. loose stools) **STOP** and inform a registered nurse.

Equipment

- Manual Handling Plan
- Sani chair
- Toilet roll/Disposable wipes
- Apron/Gloves
- Soap, water, towel
- Disinfectant wipes

Procedure

18. Introduce yourself to the child and parent/carer and give an explanation of the planned procedure. Gain patient consent.

19. Wash hands and apply gloves and apron, in accordance with the trust infection control guideline.

20. Collect the equipment.

21. Ensure that the curtains/doors are closed around the child to provide privacy and dignity.

22. Remove any clutter from the bed area to allow the transfer to take place safely.

23. Place the Sani Chair at the bedside making sure all the brakes are on.
24. Provide the correct level of supervision/assistance to allow safe transfer on to the sani chair as directed in the manual-handling plan.

25. Release brakes and wheel the child to the toilet area. Position Sani Chair over toilet and reapply brakes.

26. If the child is able, ask them to lift their bottom up off the Sani Chair to remove clothing.

27. Explain to the child they are now on the toilet and explain the use of the pull cord call system. Ask them to ring when they require assistance but also inform them that you will keep coming back to check on them.

28. Leave the child and ensure that the door is closed to maintain the child’s privacy and dignity. Put a notice on the door to say engaged.

29. Remove gloves and apron, wash and dry hands.

30. When the child has finished on the toilet, wash hands and reapply gloves and apron before assisting the child.

31. If the child is unable to clean themselves, then ensure they are clean using toilet tissue and disposable wipes. Dispose of this in the clinical waste bin. If no assistance is required allow the child to carry out their own personal hygiene. Replace clothing.

32. Flush toilet and encourage child to wash their hands

33. Ensure child is safely seated on Sani Chair, remove brakes and wheel back to their bed space.

34. Apply the brakes before providing supervision/assistance to allow safe transfer from to the sani chair to bed/chair as directed in the manual-handling plan.

35. Ensure that the child is comfortable and their dignity needs have been met before opening the curtains.

20 Clean the Sani Chair using disinfectant wipes. Remove gloves and apron and wash and dry hands.

21 Document and record the procedure in nursing notes and fluid balance charts.

Reference
<table>
<thead>
<tr>
<th>NAME:</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
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<tr>
<td><strong>ASSISTED TOILETING- SANI CHAIR</strong></td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td>1. Introduce yourself to the child and parent/carer give explanation of the planned procedure. Gain patient consent.</td>
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<tr>
<td>2. Collect necessary equipment</td>
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<tr>
<td>2. Follow correct infection control guidelines.</td>
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<tr>
<td>3. Promote and provide privacy and dignity.</td>
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<tr>
<td>4. Understands manual handling principles and refers to the manual handling plan.</td>
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<tr>
<td>5. Provide the correct level of supervision/assistance to allow safe transfer onto and off of the Sani Chair.</td>
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<tr>
<td>6. Give the child/infant the pull cord system. Ask them to ring when they require assistance, but assure them you will make checks to ensure they are safe.</td>
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<tr>
<td>7. Assists with hygiene needs. Encourages hand washing.</td>
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<tr>
<td>8. Cleans the Sani Chair.</td>
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<tr>
<td>10. Appropriate attitudes and behaviours displayed throughout</td>
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<td>Sign and date when achieved</td>
<td>Signature of Learner</td>
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<td>Signature of Assessor</td>
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PERSONAL CARES
ASSISTED TOILETING WITH A BEDPAN

Aim

To enable the Child to empty their bladder and/or evacuate the bowel whilst bed bound, maintaining privacy and dignity throughout.

Precautions

- Standard precautions must be followed throughout.
- Presence of drains, IV fluids, dressings, traction etc.

When to stop

- If the child is being uncooperative or combative STOP and report to a registered nurse.
- If the child is unable to pass urine and/or open bowels STOP and report to a registered nurse.
- If any unusual output is noted (e.g. loose stools) STOP and inform a registered nurse.

Equipment

- Bedpan
- Conti sheet
- Toilet tissue/Disposable wipes
- Paper towels
- Gloves/ apron
- Soap, water, towel

Procedure

1. Introduce yourself the child and parent/carer give explanation of the planned procedure. Gain patient consent.

2. Wash and dry hands. Apply gloves and apron as per infection control guideline.

3. Gather the equipment.

4. Ensure that the curtains are drawn around the child to provide privacy and dignity.

5. Turn back the covers enough to position the bedpan, with a conti sheet underneath, whilst ensuring the patients dignity is maintained.
6. a) If the child/infant is able to move in the bed, ask them to lift their bottom up allowing for the bedpan to be placed underneath. The handle should be at the end nearest the patient’s feet.
   b) If the child cannot move well, you will require another person to assist you in rolling the patient onto the bedpan, using trust manual handling technique.

7. If appropriate, help the child achieve a more successful toileting position by being upright. Pillows and the use of the electric profiling bed could be used.

8. Ensure the patient is comfortable enough for toileting. Use a towel or pillow case over the hips to maintain dignity.

9. Leave the child and ensure that curtains/doors around the child are closed to maintain the child’s privacy and dignity. Give the child the nurse call button and ensure they can use it. Ask them to ring when assistance is required, but also inform them you will keep coming back to check they are ok.

10. Remove gloves and apron, wash and dry hands while waiting for the child to finish. When the child has finished toileting, wash hands and reapply gloves and apron before assisting the patient.

11. Remove the bedpan and conti sheet by either the child lifting their hips or by rolling them to the side.

12. If the child is unable to clean themselves then ensure that they are clean using toilet tissue and disposable wipes. Dispose of these into the clinical waste bin. Ensure that the bed linen and child’s clothing remains clean during this procedure and replace if not.

13. Encourage the child to clean their hands.

14. Take the bedpan (covered with paper towels) to the dirty utility room and dispose into the sluice. Wash bedpan in the bedpan washer.

15. Remove gloves and apron and wash and dry hands.

16. Return to the child and ensure that they are comfortable and dignity needs have been met before opening the curtains.

17. Document and record the procedure in the nursing notes and fluid balance charts.

References

<table>
<thead>
<tr>
<th>NAME:</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
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<tbody>
<tr>
<td>PERSONAL CARES- ASSISTED TOILETING WITH A BEDPAN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td>1. Introduce yourself to the child, parent or carer and explain the procedure. Gain child’s consent.</td>
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<tr>
<td>2. Follow correct Infection Control Procedure and wash hands thoroughly, apply gloves and apron.</td>
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<tr>
<td>3. Collect necessary equipment</td>
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<tr>
<td>4. Ensure the curtains are drawn around and covers/clothing are in place to provide privacy and dignity.</td>
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<td>5. Place and remove bedpan safely by either the child to lifting their bottom to allow for the bedpan to be placed correctly or by rolling the patient onto the bedpan in accordance with manual handling guidelines.</td>
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<td>6. If appropriate, use pillows or the electric profiling bed to help the child/infant to sit upright to achieve a more successful toileting position.</td>
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<td>7. Give the child the nurse call button and explain how to use it. Ask them to press the buzzer when they require assistance but check them.</td>
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<td>8. Offer assistance with hygiene using toilet tissue/disposable wipes and encourage the child/infant to clean their hands.</td>
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<td>9. Cover the bedpan with paper towels and transport to the dirty utility, dispose down the sluice and clean in the bedpan washer.</td>
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<td>10. Document and record the procedure in the nursing notes &amp; fluid balance charts.</td>
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<tr>
<td>11. Appropriate attitudes and behaviours displayed throughout</td>
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Sign and date when achieved

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<th>Signature of Learner</th>
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<tr>
<td>Signature of Assessor</td>
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<td>Date of Review</td>
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</table>
PERSONAL CARE
EYE CARE

Aim
To ensure eyes are clean and free of any discharge or debris.

Precautions
- Eyes should not be routinely cleaned unless the child/infant has a suspected or actual infection, encrustation, excessive stickiness or a specified disease.
- Eye care may need to be more frequent if child/infant is unable to naturally lubricate the eyes themselves.
- Neonates may need eye care up to 4 times daily to clear ‘sticky’ eyes.
- Do not use cotton wool

When to stop
- If eyes have increased stickiness/encrustation STOP inform the nurse looking after the patient before cleaning the eyes in case it may be a sign of infection.
- When ointment or drops are prescribed STOP get a registered nurse to administer them.

Equipment
- Sterile water or cool boiled tap water
- Sterile container/galipot
- Sterile gauze
- Gloves and Apron

Procedure
1. Identify the appropriate timescale for undertaking the procedure
2. Introduce yourself to the child/parent/carer, explain what you are going to do and gain consent.
3. Collect the equipment
4. Wash your hands as per infection control guideline.
5. Position baby/child on a flat surface and swaddle as appropriate.
6. Pour sterile water into galipot and open the gauze
7. Using gauze, one at a time wet the corner piece of the gauze and wipe eye from inside edge to outside along the bottom lid in a single motion. Discard the gauze.
8. Continue cleaning the eye by repeating the above step until eye is clean. Dry the eye using a dry gauze.

9. Repeat the procedure for other eye ensuring separate gauze are used for each eye.

10. Discard equipment and wash hands as per infection control guidelines.

11. Remove swaddle and document the procedure in nursing notes.

References

<table>
<thead>
<tr>
<th></th>
<th>PERSONAL CARE- EYE CARE</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
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<tbody>
<tr>
<td>1</td>
<td>Introduce yourself to the child/parent/carer, explain what you are going to do and gain consent</td>
<td>DATE &amp; SIGN</td>
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<td>2</td>
<td>Collect the equipment</td>
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<tr>
<td>3</td>
<td>Wash your hands as per infection control policy</td>
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<td>4</td>
<td>Position baby/child on a flat surface and swaddle as appropriate</td>
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<td>5</td>
<td>Pour sterile water into galipot and open the gauze</td>
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<td>6</td>
<td>Using gauze one at a time wet the corner piece of the gauze and wipe eye from inside edge to outside along the bottom lid in a single motion. Discard the swab</td>
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<td>7</td>
<td>Continue cleaning the eye by repeating the above step until eye is clean. Dry the eye using a dry swab.</td>
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<td>8</td>
<td>Repeat the procedure for other eye ensuring separate swabs are used for each eye.</td>
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<tr>
<td>9</td>
<td>Discard equipment and wash hands as per infection control guidelines.</td>
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<tr>
<td>10</td>
<td>Remove swaddle and document the procedure in nursing notes.</td>
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Sign and date when achieved

- Signature of Learner
- Signature of Assessor
- Date of Review
PERSONAL CARES
MOUTH CARE

Aim

To maintain oral hygiene for those who are unable to carry out the procedure themselves.

Precautions

- Patient may suffer from oral phobia.
- Seek advice from a senior member of staff before beginning the procedure if you notice any of the following: bleeding gums, mouth ulcers, cold sores or dry, cracked lips.
- Patients who have airway/ swallowing difficulties should be discussed with the registered nurse.
- Teeth should be cleaned for 2-3 minutes, twice a day.

When to stop

- If the patient complains of pain or you notice any bleeding during the procedure STOP and report to the nurse in charge immediately.
- If the patient’s colour or breathing changes or they have excess coughing STOP and call for help.

Equipment

- Disposable gloves and apron
- Disposable receiver
- Cup
- Toothpaste
- Soft, small headed paediatric toothbrush/pink sponge
- Paper tissues
- Pen torch
- Sterile water for children under 1
- Yellow paraffin

Procedure

27. Introduce yourself to the child/parent/carer. Give an explanation of the planned procedure and gain patient consent.

28. Collect and prepare equipment, taking note of any personal preferences such as type of toothpaste used.

29. Ensure privacy by closing the curtains around the bed space and reduce any draughts by closing windows/doors.
30. Clear the bed table to accommodate equipment tray.

31. Wash hands as per infection control guidelines. Apply gloves and apron.

32. Inspect the patient’s mouth, with the aid of a pen torch, for any changes in condition of mouth i.e. ulcers, bleeding gums or infection. Inform the nurse of changes.

33. Add a pea sized amount of toothpaste to the brush then clean the teeth by holding the brush against the teeth at a 45° angle. Move the bristles back and forth from the gum to the crown of the tooth using a vibrating motion until all the surfaces have been cleaned. Clean the biting surfaces by moving the toothbrush over them in short strokes. Gently brush roof of mouth, gums, inside of cheeks + tongue avoiding triggering gag reflex. For children without teeth use a pink sponge in sterile water.

34. Encourage the child to spit out excess toothpaste. Deter them from swallowing.
   (a) If physically able give them a glass of water or mouthwash and encourage them to rinse their mouth vigorously before spitting the fluid into a disposable receiver. Provide tissues so they can dry their mouth.
   (b) If the patient is unable to rinse their mouth use a rinsed toothbrush to wipe over the teeth and gums then wipe the mouth with tissues. Suction mouth if secretions occur.

35. Apply thin layer of soft yellow paraffin to lips, or patients own lip balm.

36. Clean and tidy bed area and table top, disposing of all disposable equipment in the correct bin.

37. Remove gloves and apron and dispose of in the clinical waste bin. Wash hands as per infection control guidelines.

38. Document cares carried out in the appropriate nursing documentation.

References
1. Sheffield Children’s Hospital Infection Control Policy
<table>
<thead>
<tr>
<th>NAME:</th>
<th>Personal Cares – mouth care</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
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<td>DATE &amp; SIGN</td>
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<td>DATE &amp; SIGN</td>
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<tr>
<td>1</td>
<td>Check patient identity, give explanation of the procedure and gain consent.</td>
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<tr>
<td>2</td>
<td>Wash hands as per infection control guidelines.</td>
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<tr>
<td>3</td>
<td>Collect necessary equipment.</td>
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<tr>
<td>4</td>
<td>Ensure patient’s privacy and dignity is maintained.</td>
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<tr>
<td>5</td>
<td>Clear bed table to accommodate equipment tray.</td>
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<tr>
<td>6</td>
<td>Inspect the patient's mouth to check for any changes in condition and feedback to nurse as appropriate.</td>
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<tr>
<td>7</td>
<td>Apply toothpaste to brush then clean the teeth following the correct procedure.</td>
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<td>8</td>
<td>Rinse the mouth using the appropriate method.</td>
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<tr>
<td>9</td>
<td>Clean and tidy bed area and table top.</td>
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<tr>
<td>10</td>
<td>Dispose of equipment, gloves and apron as necessary and wash hands.</td>
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<tr>
<td>11</td>
<td>Document cares carried out in the appropriate nursing documentation.</td>
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<tr>
<td>12</td>
<td>Appropriate attitudes and behaviours displayed throughout</td>
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Sign and date when achieved | Signature of Learner | Signature of Assessor | Date of Review |
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PERSONAL CARES: NAPPY CARES

Aim
To minimise the risk of damage to the skin caused by prolonged contact with urine or faeces

Precautions
- Universal precautions for infection control must be followed throughout.
- Use manual handling techniques.
- Some infants have specific patient guidance in regards to moving and handling.

When to stop
- If the child’s condition has deteriorated **STOP** and discuss with a registered nurse.
- If the child’s skin appears broken down or red/sore and inflamed (excoriated) **STOP** and inform a registered nurse.

Equipment
- Appropriate size nappy
- Wipes and water or appropriate baby wipes
- Any nappy creams that have been prescribed for the child. These must be checked by a registered nurse against the drug card before use.
- Gloves and disposable apron

Procedure
1. Wash and dry hands as per infection control policy.
2. Introduce yourself to the child, parent or carer and explain what you are going to do.
3. Ensure all necessary equipment is within reach.
4. Open existing nappy and assess contents
5. Clean the child’s skin from front to back ensuring all body fluids are removed from the child’s skin.
6. Check the child’s skin for any signs redness or excoriated areas. If any noted inform the child’s nurse.
7. If the child has any nappy creams in use ensure they are prescribed as per guidelines.

8. Replace the new nappy.

9. If the child does not need strict fluid balance monitoring dispose of soiled nappy and any wipes or waste according to infection control guidelines.

10. If the child needs strict fluid balance monitoring weigh the nappy and deduct the weight of the dry nappy and record this on the child’s fluid chart.

11. Wash and dry hands.


13. Report any abnormal findings e.g. loose stools or excessive output to the child’s nurse.

References

2. Sheffield children’s NHS Foundation Trust (2016) Control of infections Policy
<table>
<thead>
<tr>
<th>NAME:</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
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<td>DATE &amp; SIGN</td>
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<tr>
<td>Introduce yourself to family/child/carer and gain consent after explaining the procedure.</td>
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<tr>
<td>Demonstrates knowledge of infection control guideline, hand washing and using PPE</td>
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<tr>
<td>Open the nappy and clean the child’s skin from front to back ensuring all bodily fluid is removed.</td>
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<tr>
<td>Observe the child’s skin for any signs of break down</td>
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<tr>
<td>Safely apply any appropriate nappy cream which has been checked by a registered nurse</td>
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<td>Dispose of all waste appropriately.</td>
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<tr>
<td>Identifies when to weigh the nappy or not.</td>
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<td>Record fluid output accurately.</td>
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<td>Report any concerns to the child’s nurse</td>
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<td>Signature of Assessor</td>
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PERSONAL CARES
REMOVAL AND REPLACEMENT OF A BASIC WOUND DRESSING

Aim

To safely and effectively undertake removing and replacing a dressing, in adherence with aseptic non-touch technique (ANTT)

Precautions

- Infection control guidelines must be followed throughout.
- Adhere to the Aseptic Non Touch Technique (ANTT)

When to Stop

- If you are concerned about the appearance of the old dressing or wound beneath it, STOP and seek advice from a qualified member of staff.
- If you are concerned about safely removing the old dressing (e.g. the child/infant has fragile skin), STOP and seek advice from a qualified member of staff.
- If the child has not received pain relief STOP and report to a senior member of staff.

Equipment

- Trolley
- Dressing pack
- Apron & gloves
- Dressing
- Water/Saline
- Gauze

Procedure

1. Introduce yourself the child/ parent/carer and give explanation of the planned procedure. Gain patient consent. If a play specialist is available use them to assist with distraction or that they use their own toys to distract themselves.

2. With a clean trolley, gather the equipment required and place on the bottom shelf, taking care not to touch the trolley surfaces.

3. Wheel the trolley to the child’s bedside and close the curtains to maintain their privacy and dignity.

4. Wash and dry hands then apply apron, as per the Trusts Infection Control Policy.
5. (a) Without touching the inner surfaces of the dressing pack or its contents, open the dressing pack on the top shelf.
   (b) Prepare the other equipment by opening the packets onto the opened dressing pack and pouring the cleaning solution into the galipot, protecting key parts at all times.

6. Access the wound area ensuring the patient is as comfortable as possible.

7. Observe the old dressing for any signs of excess bleeding or exudate. STOP and report any cause for concern to the child’s nurse before proceeding.

8. Remove the old dressing ensuring you are careful not to cause damage to the skin. Place in the waste bag set up at the side of the trolley.

9. Wash and dry hands as per Infection Control Guidelines.

10. Apply gloves (sterile if procedure dictates) and place paper towel from the dressing pack under the wound to enhance sterility.

11. Clean the wound with water, taking care to observe the wound and surrounding tissue for any signs of infection, deterioration or allergy to the dressing. Observe and note wound size, tissue type and the presence of any wound fluid. STOP and report any cause for concern to the child’s nurse before proceeding.

12. Apply the dressing to the wound.

13. Dispose of all equipment and gloves in the waste bag attached to the trolley. Remove and seal this bag before disposing of it in the large clinical waste bin.

14. Return the trolley to the storage area and clean surfaces as detailed in “cleaning a trolley following a clinical procedure” competency.

15. Wash and dry hands as per Infection Control Policy.

16. Document procedure in nursing notes and report to the registered nurse who delegated the task.

References

5. Sheffield Children’s Hospital Infection Control Policy


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<tr>
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<th>COMPETENT</th>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td>Follow correct Infection Control Procedure and wash hands thoroughly.</td>
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<td><strong>2</strong></td>
<td>Clean trolley as per setting up a trolley competency</td>
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<td><strong>3</strong></td>
<td>Collect necessary equipment ensuring all packets are sealed and in date:</td>
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<td><strong>4</strong></td>
<td>Wheel trolley to patient’s bedside and close curtains / door to maintain privacy. Apply apron. Open the dressing pack onto the top shelf and prepare other equipment in accordance with ANTT.</td>
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<td><strong>5</strong></td>
<td>Access the wound area showing respect for patient comfort and dignity throughout. Observe the wound dressing for any signs of excess bleeding / exudates. Report any concerns to senior member of staff.</td>
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<td><strong>6</strong></td>
<td>Remove old dressing, ensuring you do not damage any of the skin. Clean the wound and observing the site.</td>
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<tr>
<td><strong>7</strong></td>
<td>Apply the dressing</td>
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<tr>
<td><strong>8</strong></td>
<td>Dispose of all equipment as per infection control guidelines.</td>
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<td><strong>9</strong></td>
<td>Correct documentation of task into the appropriate nursing notes. Feedback to registered nurse who delegated the task/ in charge.</td>
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**Sign and date when achieved**

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<th>Signature of Learner</th>
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PERSONAL CARE
URINARY CATHETER CARE

Aim

- To ensure urethral catheter site is kept clean to reduce infection into urinary tract.
- To ensure positioning of catheter does not cause pressure sores.

Precautions

- Catheter care should be completed daily as more frequently may cause infection.

When to stop

- If skin around catheter looks sore, broken down (excoriated) or infected, **STOP** and seek advice from nurse responsible for patient. You may need to obtain a swab. The nurse may consider obtaining a urine sample to perform urinalysis or send for MC&S.
- If there is bleeding, discharge or inflammation, **STOP** and inform the nurse responsible for the patient who must inform the Medical staff.

Equipment

- Non sterile gloves
- Plastic apron
- Dry wipes
- Bowl
- Soap and water
- Sterile 0.9% saline for suprapubic catheter
- Mefix tape
- Adhesive remover if necessary

Procedure

1. Introduce yourself to the child/parent/carer, give an explanation of the planned procedure and gain consent.
2. Collect equipment ensuring it is clean.
3. Wash hands as per infection control guidelines.
4. Position child in a comfortable position in the bed.
5. Fill bowl with warm water and soap, checking the temperature using elbow tolerance.

6. Soak the dry wipes in the water. Clean the catheter and site by directing the wipe away from catheter site. Use a clean wipe each time until clean.

7. Ensure all soap is rinsed off and the area is dry.

8. Secure the catheter to the abdomen or leg using the mefix tape in a different area to prevent the catheter pulling and sores forming.

9. Clean and tidy the bed space and equipment used. Dispose of equipment in the correct bin.

10. Remove gloves and apron and dispose of in the clinical waste bin. Wash hands as per infection control guidelines.

11. Document cares in the appropriate nursing notes.

References

### Urinary Catheter Care

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<th>Taught</th>
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<tbody>
<tr>
<td>Explain the procedure to child/parent/carer and gain consent.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td>Gather the equipment needed ensuring they are all clean as per infection control guidelines.</td>
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<td>Wash hands as per infection control guidelines.</td>
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<td>Position child in a comfortable position in the bed.</td>
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<tr>
<td>Using dry wipes soaked in warm soapy water clean the catheter site by directing the wipe away from catheter site. Use a clean wipe each time until clean.</td>
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<tr>
<td>Ensure all soap is rinsed off and area is dry.</td>
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<tr>
<td>Secure the catheter to the abdomen or leg using the mefix tape.</td>
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<tr>
<td>Dispose or clean equipment appropriately.</td>
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<tr>
<td>Wash hands as per infection control guidelines.</td>
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<td>Document in nursing notes.</td>
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PERSONAL CARE
PRESSURE AREA CARE

**Aim**

To minimise skin breakdown or pressure ulcer by observing the skin condition for potential problems and providing pressure area care as indicated by the Skin Integrity Tool (CAEC 1560).

**Precautions**

- Skin breakdown is associated with premature fragile skin, skin disease, adhesive dressings, burns, infections, trauma, surgery.
- Pressure Ulcers are caused by either compression, shearing, friction. Moisture can also cause skin breakdown.
- Pressure ulcers can develop in any area of the body but generally occur over bony prominences.
- Pressure damage can be caused by equipment or devices such as lines, splints, probes, etc.

**When to stop**

- If skin appears red, broken, blistered or bruised or patient complains of pain or discomfort **STOP** and inform the registered nurse responsible for the patient.
- If patient is uncooperative, combative or confused or you are unsure how to reposition the patient **STOP** and ask for help.

**Equipment**

- Skin Integrity Tool with assessment completed.
- Manual handling equipment

**Procedure**

1. Introduce yourself to the child, family or carers. Explain the procedure and gain consent.

2. Wash hands and use personal protective equipment as per infection control policy.

3. Close windows to minimise drafts, close the curtains around the bed space and maintain privacy at all times.

4. Check the patient’s skin focusing on bony prominences for skin redness, breakdown or blistering.
5. Ensure skin is kept clean and dry. Do not use soap that will dry the skin, instead use aqueous cream in any patient at risk of skin ulcer.

6. Relieve pressure by encouraging the child to move or reposition themselves.

7. If the patient is unable to move themselves use manual handling techniques to assist the patient to move from side to back to side lying and avoiding rubbing or dragging of the child’s skin.

8. Turn 2 to 4 hourly or as condition allows.

9. Consider using pillows to position patients off of their bony prominences or to aid a 30 degree tilt.

10. Consider using a pressure relieving mattress for patient that are difficult to turn, mark easily or at high risk of pressure ulcer.

11. Move saturation probe sites 4 hourly.

12. Check that no equipment or object is pressing against the skin.

13. Ensure the child is covered by a sheet or clothes and open the curtains.

14. Wash hands and equipment

15. Document skin condition and turn in the nursing notes.

References


2. Sheffield Children’s NHS Foundation Trust (2014) Assessment and Maintenance of Skin Integrity Using the Skin Integrity Tool in SCH


### PERSONAL CARE: PRESSURE AREA CARE

<table>
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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Introduce yourself to the child/parent/carer, explain what you are going to do and gain consent</td>
<td>Date and Sign</td>
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<tr>
<td>2.</td>
<td>Collect the equipment</td>
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<td>3.</td>
<td>Adhere to Infection Control guidelines throughout.</td>
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<td>4.</td>
<td>Check skin for redness, breakdown or blisters</td>
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<td>5.</td>
<td>Check skin is clean and dry. Understands what soap type to use.</td>
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<td>6.</td>
<td>Positions patient appropriately to relieve pressure areas using manual handling techniques at an appropriate frequency.</td>
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<td>7.</td>
<td>Considers the use of pressure relieving mattress.</td>
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<td>8.</td>
<td>Repositions saturation probe and observes site for skin damage.</td>
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<td>9.</td>
<td>Checks for equipment and objects that may be causing pressure on the skin</td>
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<td>10.</td>
<td>Maintains the patient’s dignity at all times</td>
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<td>11.</td>
<td>Document the procedure in nursing notes.</td>
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NUTRITION: EATING & DRINKING

Aim

To ensure adequate nutrition and hydration for all children, including those that require assistance with feeding and drinking.

Precautions

- Infection control guidelines must be followed throughout.
- Check that the selected meal meets the individuals dietary requirements.

When to stop

If you notice any difficulties with swallowing, **STOP** and seek immediate assistance from a registered nurse.

Equipment

- Apron
- Appropriate utensils
- Appropriate seating (age appropriate)

Procedure

1. Introduce yourself the child/infant and parent/carer give explanation of the planned procedure. Gain patient consent.

2. Establish the level and type of support required with eating and drinking by speaking to the child and their carers, and checking the plan of care.

3. Wash and dry hands as per Infection Control Guidelines and apply apron.

4. Encourage the child to wash their hands.

5. Assist the child to achieve a position that is appropriate for eating and drinking and is consistent with their abilities and their plan of care.

6. Check you have the correct meal and provide the appropriate utensils to enable feeding and drinking according to the child’s needs and their plan of care.
7. Cut up food into manageable pieces and assist child with feeding where required. **STOP** if any signs of deterioration in the child’s condition or previously unknown difficulties in swallowing.

8. Confirm that the child has finished eating and drinking before clearing away. Ensure the bed area and table top are left clean and tidy.

9. Encourage the child to wash their hands.

10. Remove apron and dispose of in the appropriate waste bin.

11. Wash and dry hands, as per infection control policy.

12. Document the amount of food and drink consumed and the level of assistance given on the child’s fluid balance chart.

13. Report any concerns to a senior member of staff.

References


Sheffield Children’s NHS Foundation Trust (2016) Food Safety Policy. SCH Corporate Policy (CP 1534)


<table>
<thead>
<tr>
<th>NUTRITION – EATING AND DRINKING</th>
<th>TAUGHT</th>
<th>MODELLED</th>
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<tr>
<td><strong>1</strong> Introduce yourself the child/infant and parent/carer give explanation of the planned procedure. Gain patient consent. Establish the level and type of support required.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
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<tr>
<td><strong>2</strong> Adhere to Infection Control Guidelines Throughout. Use PPE appropriately</td>
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<td><strong>3</strong> Assist the child to achieve a position that is appropriate for eating and drinking</td>
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<td><strong>4</strong> Encourage the child to wash their hands before and after the meal</td>
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<td><strong>5</strong> Check you have the correct meal and provide the appropriate utensils to enable feeding</td>
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<td><strong>6</strong> Cut up food into manageable pieces and assist child with feeding where required.</td>
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NUTRITION
GASTROSTOMY TUBE CARE AND GIVING A BOLUS FEED

Aim
• To safely care for the child with a gastrostomy tube.
• To safely administer a bolus feed via a gastrostomy tube.

Precautions
• To understand the rationale for the need of the gastrostomy tube.
• To be aware of potential complications that can arise from gastrostomy feeding.

When to stop
• If the child’s condition deteriorates during the feed STOP and report to the child’s nurse.

Equipment
• Gloves and apron.
• Sterile water or saline
• Gauze
• Gallipot
• Feed
• 10ml syringe
• 20ml or 60ml syringe.

Procedure
1. Check that the tube site is clean and dry. Note any signs of redness swelling or leakage around the site. STOP and inform the child’s nurse if any of these signs are present.

2. Clean the site daily. Put sterile water or saline in the gallipot. Use gauze to wipe away from the site. Use a new gauze each time until clean. Dry the site with gauze.

3. Check that the type and volume of feed is correct according to the dietician plan or nursing care plan.

4. Wash hands as per infection control guidelines.

5. Draw up 5-10mls of water (sterile if under 1 years old). Attach syringe to the gastrostomy tube. Unclamp, flush, clamp and unattach syringe.

6. Remove the plunger from a 20ml or 60ml enteral syringe (purple) and attach the barrel of the syringe to the child’s tube. Keep the clamp on to prevent air being introduced or gastric aspirate leaking.

7. Pour the required amount of milk into the syringe. Undo the clamp and allow the milk to fall naturally through the tube using gravity.
8. If the child coughs or moves during the feed be prepared to clamp the tube again to prevent backflow.

9. Once the milk has been given flush the tube with 5-10ml of water as before (sterile if under 1 years old).

10. Document the feed on the child’s fluid balance chart.

References
1. Sheffield Children’s NHS Foundation Trust (2015) Nursing Core care plan for a child following fundoplication and/or insertion of a Gastrostomy or Jejunostomy (Corflo PEG, Fresenius PEG, one step Mickey Button, Balloon device) (32)
<table>
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<tr>
<th></th>
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<td>Check that the tube site is clean and dry. Note any signs of redness swelling or leakage around the site</td>
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<td>Clean the site appropriately.</td>
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<td>Check that the type and volume of feed is correct according to the dietician plan or nursing care plan as appropriate.</td>
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<td>4</td>
<td>Wash hands as per infection control guidelines.</td>
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<td>5</td>
<td>Flush the tube with 5-10mls of water (sterile if under 1 year of age).</td>
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<td>6</td>
<td>Give the feed correctly.</td>
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<td>7</td>
<td>Flush the tube with 5-10ml of water (sterile if under 1 year of age).</td>
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<td>8</td>
<td>Document the feed on the child’s fluid balance chart.</td>
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- Signature of Assessor
- Date of Review
NUTRITION
NASOGASTRIC TUBE CARE AND GIVING A BOLUS FEED

Aim
- To safely care for the child with a nasogastric tube.
- To safely administer a bolus feed via a nasogastric tube.

Precautions
- Ensuring that the tube position has been checked by a qualified practitioner.
- To understand the rationale for the need of the nasogastric tube.
- To be aware of potential complications that can arise from nasogastric feeding.
- Be aware of the effect that different milk types can have on the ability to test the position of the tube. Some milks may be absorbed more quickly so the stomach will empty quicker. Also some milks will affect the ph of the aspirate obtained.

When to stop
- **STOP** if the position of the nasogastric tube has not been confirmed by a qualified practitioner.
- If the child’s condition deteriorates during the feed **STOP** and report to the child’s nurse.

Equipment
- Gloves and apron.
- pH strips.
- Feed
- 20ml syringe
- 60ml syringe.

Procedure
11. Check that the tapes securing the tube are firmly attached to the child’s face, are clean and in good condition.

12. If the tapes are not secure or are damaged replace them, ensuring the tube doesn’t slide out. Seek assistance if necessary

13. Check that the type and volume of feed is correct according to the dietician plan or nursing care plan.

14. Wash hands as per infection control guidelines.

15. Using a 20ml syringe aspirate at least 0.5mls from the tube. Test this aspirate using a pH strip. Take note of the pH and the tube length.
16. If a suitable aspirate cannot be obtained seek advice from a qualified practitioner.

17. Show a qualified practitioner the pH strip and inform them of the length of the tube. Only once they are happy with the tube position can you proceed to feed the child.

18. Remove the plunger from a 20ml or 60ml enteral syringe (purple) and attach the barrel of the syringe to the child’s tube. Bend the end of the tube while doing this to prevent air being introduced or gastric aspirate leaking.

19. Pour the required amount of milk into the syringe. Allow the milk to fall naturally through the tube using gravity.

20. If the child coughs or moves during the feed be prepared to bend the tube again to prevent backflow.

21. Once the milk has been given flush the tube with 5-10ml of water as before (sterile water if under 1 year old). Unless the dietician plan states a larger amount.

22. Document the feed, pH reading and length on the child’s fluid balance chart.

References


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<td>1</td>
<td>Check that the tapes are clean and secure.</td>
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<td>Check that the type and volume of feed is correct according to the dietician plan or nursing care plan as appropriate.</td>
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<td>Wash hands as per infection control guidelines.</td>
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<td>4</td>
<td>Test the tube, checking with a qualified practitioner.</td>
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NUTRITION
ORDERING MEALS

Aim

To order appropriate quantity and types of food to ensure patients have an individualised and balanced diet, which is appropriate to their medical needs. To ensure that Breastfeeding mothers have access to appropriate nutrition while in hospital. Ensure food is ordered in a timely manner to ensure it is prepared in time.

Precautions

- Allergies/ intolerances/ eating disorders.
- Difficulties with swallowing – ordering appropriate texture of food
- Be aware of nil by mouth – if child will be able to eat later consider ordering meal for teatime trolley.

When to stop

- If the child or carer is ordering a meal which goes against medical or dietician plan of care STOP and inform the child’s registered nurse.

Equipment

- Correct menus for the relevant week (week 1, 2 or 3) – one per child
- Pen
- “Ward ordering sheet for kitchen”
- Special/ restricted diet menus available
- Requisition slips for breastfeeding mothers

Procedure

1. Collect necessary equipment
2. Distribute menus to all patients requiring meals and encourage patients/parents to complete if able.
3. If the patient or carer is unable to order independently assist them to choose what they would like.
4. Collect all menus in from patients before 9AM so that order can be placed with the kitchen before 9.30 AM.
5. Collate orders onto “Ward ordering sheet for kitchen”.
6. Take photocopy of ward ordering sheet.
7. Keep one copy on the ward and take one copy to the kitchen.

8. If new patients are admitted through the course of the day encourage the patient or carer to select choice of meal. This can then be telephoned through to the catering department for delivery at the next available mealtime.

9. Breastfeeding mothers or those expressing breastmilk for their child should be encouraged to order meals from the menu. The order should then be copied onto the separate requisition slip and sent to the kitchen.

References

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<th>Nutrition – Ordering meals</th>
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NUTRITION
SERVING MEALS

Aim
To safely serve and deliver meals provided by the catering department to patients on the ward.

Precautions
- Take account of the child’s age, developmental state, appetite and medical condition.
- Ensure the food trolley is plugged in at all times until all meals are distributed in order to maintain the correct temperature.
- Be aware of any changes in child’s condition since ordering the meal which may mean they are less able to eat.

When to stop
- If the trolley fails to maintain temperature **STOP** and report to a registered nurse.
- If the food appears under or overcooked **STOP** and report to the nurse in charge and liaise with the catering department.

Equipment
- Age appropriate cutlery, crockery, trays.
- Green apron
- Serving equipment
- Patient orders

Procedure
1. Wash hands as per infection control policy.
2. Apply green apron.
3. Ensure trolley is plugged in and ensure hotplate has reached 60°C before removing the food from the trolley.
4. Place all hot food onto the hotplate and cold food onto the shelf above.
5. Serve meals as requested on the individual menus using the portion guides available.
6. Deliver the meal to the child and ensure they are in a position to eat it and have the appropriate utensils.

7. Offer the child a drink if required.

8. Revisit patients to ensure they are managing their meals and whether they need assisting to eat.

9. After appropriate time has been allowed for patients to eat their meals, ensure that all waste, crockery and cutlery are collected and returned to the ward kitchen.

10. Document what the child has eaten on the child’s fluid balance chart and report any concerns to the child’s nurse.

References


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Sign and date when achieved

- Signature of Learner
- Signature of Assessor
- Date of Review
INVESTIGATIONS
TAKING A STOOL SAMPLE

Aim

To collect a stool using the correct technique that avoids cross infection and ensure that it is delivered to the correct laboratory for testing.

Precautions

- Where diarrhoea is present a small piece of absorbent material can be used to line the nappy.
- To know if the sample is for microbiology, virology and/or clinical chemistry.
- Stool specimen is preferable to rectal swab

When to stop

- If a stool swab has not been obtained within 6 hours **STOP** and inform the nurse responsible for the child.
- If tape worm segment is seen in stool matter **STOP** and inform the registered nurse so that a specimen can be collected.

Equipment

- Appropriate sized nappy
- Clean potty/ collection pot
- Blue lidded faecal specimen pot with scoop
- Material
- Gloves

Procedure

1. Introduce yourself the child/infant and parent/carer give explanation of the planned procedure. Gain patient consent.

2. Collect all necessary equipment.

3. Wash hands as per the Trusts infection Control policy.

4. Put on gloves and apron.

5. Using the scoop attached to the lid of the pot, place faecal material into the container.
6. Examine the sample for consistency, odour and blood.

7. Dispose of gloves/apron and wash hands.

8. Document and record the procedure in nursing notes.

References

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<th>NAME:</th>
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<td>Collect all necessary equipment.</td>
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<td>Wash hands as per the Trusts infection Control policy.</td>
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<td>Put on gloves and apron</td>
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<th>Signature of Assessor</th>
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INVESTIGATION:
OBTAINING A CLEAN CATCH URINE SAMPLE

Aim

To obtain a clean sample which can be used to detect or rule out the presence of a urine infection.

Precautions

- Do not undertake if the child has profuse diarrhoea.
- Inform the registered nurse if undertaking test while menstruating.
- Inform the registered nurse if undertaking test if heavy haematuria present.
- Avoid sitting the child in the receiver as this increases the risk of a contaminated sample.
- Liaise with the child’s registered nurse to consider the need for pregnancy test.

When to stop

- If the patient is unable to provide a sample STOP and report to the nurse in charge.

Equipment

- Disposable receiver/bedpan
- Disposable bedpan cover
- Disposable gloves and apron
- Universal container

Procedure

1. Collect the necessary equipment.

2. Wash & dry hands as per Infection Control Policy.

3. Check patient identity and give explanation of the planned procedure, gain patient consent.

4. (a) If using the toilet provide the patient with a disposable receiver/bedpan. Lift the seat, place the receiver/bedpan over the toilet bowl then replace the seat to hold the receiver/bedpan in place.

   (b) If using a commode ensure the environment is free from clutter the close the bedside curtains. The receiver/bedpan should be placed under the commode seat to keep it in place.
c) If the child usually wears nappies ensure the child is cleaned thoroughly and place a sterile receiver close to the urethral opening.

5. Once the sample has been provided wash hands and apply disposable gloves and apron as per Infection Control Policy.

6. Ensure patient safely returns to their bed area and is comfortable.

7. Cover the receiver with disposable bedpan cover and take the sample to the dirty utility room.

8. Transfer the sample to a universal container as soon as possible and replace the lid. Label the sample with the patient’s details.

9. If the child is under 2 years of age the sample should be sent for urgent microscopy and culture. If the child is over 2 years of age urinalysis of the sample should be carried out by a trained member of staff prior to the sample being sent to the laboratories.

10. Ensure the results are stuck in the patient’s notes and reported to a registered nurse.

11. Dispose of the bedpan and other used equipment in the appropriate clinical waste bin.

12. Remove gloves and apron then wash and dry hands as per Infection Control Policy.

References

1. Sheffield Children’s NHS Foundation Hospital (2016) Guideline for the management of urinary tract infection. SCH Guideline (CAEC 1110)
<table>
<thead>
<tr>
<th>NAME:</th>
<th>INVESTIGATION- OBTAINING A CLEAN CATCH URINE SAMPLE</th>
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<td>Collect necessary equipment.</td>
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<td>2</td>
<td>Follow correct Infection Control Procedures and wash hands thoroughly. Use appropriate PPE</td>
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<td>3</td>
<td>Check patient’s identity and give appropriate explanation of the task and obtain consent.</td>
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<td>4</td>
<td>Shows appropriate technique to obtain a clean catch sample based on age and understanding of child.</td>
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<td>5</td>
<td>Dispose of the receiver/bedpan and other used equipment correctly.</td>
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<td>6</td>
<td>Promotes privacy and dignity throughout.</td>
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<td>7</td>
<td>Report findings immediately to the nurse in charge. Stick the results sheet in the patient’s notes</td>
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<td>8</td>
<td>Appropriate attitudes and behaviours displayed throughout</td>
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INVESTIGATIONS
REMOVING AN IV CANNULA

Aim

To safely remove a cannula following IV therapy or when a change of site is required in line with Aseptic Non Touch Technique (ANTT) guidelines.

Precautions

- Check that the patient does not have any health conditions such as clotting abnormalities which may complicate the procedure.
- Ensure that infection control guidelines are adhered to.
- Check the patient is not allergic to the tape/plaster you plan to use before commencing.

When to stop

- If the patient’s condition appears to have worsened STOP and escalate to a registered nurse responsible for patient.
- If there is an infusion connected to the cannula STOP and seek assistance from the child’s nurse.

Equipment

- Disposable gloves
- Tray
- Gauze swabs
- Tape or plaster – suitable for patient
- Adhesive remover

Procedure

1. Wash hands as per infection control guidelines.
2. Collect the necessary equipment.
3. Check patient identity and give explanation of the planned procedure, gain patient consent.
4. Apply gloves.
5. Carefully removing any dressings from the cannula using adhesive remover as required. Observe condition of skin and tissue surrounding the cannula site.
6. Place the gauze swab over the puncture site with one hand whilst slowly pulling the cannula out of the vein with the other.

7. Once the cannula is removed, put it in your tray. Apply firm pressure to the gauze swab over the puncture site, elevating the limb slightly if possible.

8. After approximately 30 seconds of continued pressure, examine the site for any continued signs of bleeding. Resume pressure if bleeding persists and check at regular intervals.

9. When bleeding has stopped, observe surrounding skin for any signs of swelling or redness and report any concerns to a senior member of staff.

10. Apply a plaster or clean gauze swab to the site and secure with tape.

11. Dispose of used equipment in a clinical waste bin.

12. Remove and dispose of gloves. Wash hands as per infection control guidelines.

13. Document all actions in the notes & feedback to the child’s nurse.

Reference

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<tr>
<th>NAME:</th>
<th>Removing An IV Cannula</th>
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<td>Check patient identity and give explanation of the planned procedure, gain patient consent.</td>
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<td>Removes IV cannula safely.</td>
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<td>Dispose of cannula and equipment appropriately.</td>
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<td>6</td>
<td>Apply a plaster or clean gauze swab to the site and secure with tape.</td>
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INVESTIGATIONS
OBTAINING A ROUTINE SWAB

Aim

To help diagnose any infection the child may have, and enable the right course of treatment.

Precautions

- Be aware of the type of swab available and what each are used for.
- No medication to be given to the area that requires swabbing.
- Eye swab is not included in this competence.

When to Stop

If the child’s wound or skin looks sore, pustular or has excessive discharge (exudate) STOP and report to a registered nurse.

Equipment

- Gloves
- Swab (bacterial/ black viral/ green per nasal/ orange)
- Lab form and bag
- Sterile saline (if required)
- Tray for transport container

Procedure

1. Introduce yourself the child/infant and parent/carer give explanation of the planned procedure. Gain patient consent. Negotiate what involvement the parent/carer wishes to have.

2. Wash hands in accordance with infection control guideline.

3. Swaddle or hold the child in a comfortable position.

4. Apply gloves

5. Using the correct coloured sterile swab obtain a specimen for:

a) ear – Only swab outer ear and gently rotate to collect secretion.

b) eye – Ask the child (if able) to look upwards and gently pull the lower lid down. Gently role the swab inside the lower lid.
c) nose – If nose is dry moisten sterile swab with sterile saline. Insert swab up the nostril to top of the nose and gently rotate.

d) throat – Either ask the child to say “aahh” or if child is unable to do this use a tongue depressor/wooden spatula to depress the tongue, then quickly but gently rub the swab over the tonsil bed area or where there is pus/ exudate/ lesion.

e) wound – This should be obtained prior to any cleaning or dressing change. Using a swab gently rotate on the area.

f) skin – If skin is dry, moisten sterile swab with sterile saline and gently rotate over lesion/skin.

5. Label container and place inside laboratory bag with full name, hospital number, date of birth, date and time of collection.

6. Place in collection container.

7. Remove and dispose of gloves, wash and dry hands.

8. Document and record the procedure carried out in the nursing notes.

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<td>Wash hands and wear PPE in accordance with infection control guideline.</td>
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<td>3.</td>
<td>Knows which swab to use for the correct laboratory or sample.</td>
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<td>4.</td>
<td>Demonstrate the correct techniques for attaining a swab.</td>
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<td>5.</td>
<td>Label container correctly and place inside laboratory bag.</td>
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DOCUMENTATION: PEWS RECORDING

Background

An early warning score is formed by combining scores from routine observations and is designed to provide early indication of a patient who is deteriorating. This competency uses the PEWS charts in use at Sheffield Children’s Hospital (Sept 2016).

Aim

To correctly document a score in order to identify the deterioration in a child’s condition and identifies when to escalate to senior staff. It is trust policy that a PEWS score is completed every time observations are carried out.

Precautions

- Before completing a set of observations read care plan regarding frequency of observations.
- Use the correct PEWS chart based on the child’s age (0-1 year, 1-5 years, 5-12 years, 12 years) as thresholds for observations vary.
- The scoring system does not take the place of clinical judgement and occasionally a patient may score less than 3 and still require medical attention or advice. Don’t wait for the score to get worse before you get help.

When to stop

If the PEW score reading is 1 or above **STOP** and inform the registered nurse responsible for the child.

Procedure

1. Having carried out the observations required chart the appropriate score for each of the infant’s/ child’s physiological measurements on the age appropriate PEWS chart (respiratory rate, Oxygen saturations, receiving oxygen, respiratory distress, heart rate, BP)

2. Complete all required sections then add up the score for any results falling in the colour coded boxes where white = 0, yellow = 1, orange= 2 and pink = 4.

3. Document the score in the PEWS score section of the chart with score 1-4 in the yellow, 5-8 in the orange and >8 in the pink.

4. The child’s conclusion level (using AVPU) and pain score are documented for each observation and the child’s temperature and blood sugar levels are documented.
5. The child’s temperature, con level (using AVPU), blood sugar and pain score do not contribute to the PEWS score.

6. Inform the nurse caring for the patient if the PEWS score is anything other than 0. The registered nurse must then follow the PEWS guideline as documented for information below.

7. It is a mandatory requirement for service users to have observations and PEWS documented a minimum of 12 hourly.

References


For Information

Depending on the total PEWS score the following action should be taken by the nurse caring for the child:
- PEWS score is 0 continue to monitor as planned.
- PEWS score 1-4 discuss with nurse in charge and consider increasing frequency of observations
- PEWS score 5-8 or reduced consciousness, inform nurse in charge and ensure medical advice is sought. Observations should be repeated within 15 minutes and then at an increased frequency determined by medical review. (1)
- PEWS score >9 or reduced conscious level ensure medical review is sought and PICU are informed.
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<td>12.</td>
<td>Use appropriate infection control strategies throughout</td>
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<td>13.</td>
<td>Ensure age appropriate PEWS chart is used.</td>
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<td>14.</td>
<td>Chart the observations in the relevant areas of the chart.</td>
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<td>15.</td>
<td>Add up the total PEWS score using the appropriate score for the colour coded areas</td>
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<td>16.</td>
<td>Enter the total score in the appropriate PEWS score box.</td>
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<td>17.</td>
<td>Escalate any elevated score as per PEWS guidelines.</td>
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<td>18.</td>
<td>Recognise readings which fall outside normal and report these appropriately.</td>
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<td>19.</td>
<td>Display appropriate attitudes and behaviours throughout</td>
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**DOCUMENTATION**

**FLUID BALANCE RECORDING (ORAL OR ENTERAL)**

**Aim**

- To closely monitor input and output as part of an accurate monitoring of the patient’s condition.
- To recognise the importance of identifying any abnormal measurement and escalate to registered staff.

**Precautions**

- When documenting intake, it is your responsibility to ensure accuracy. This is best achieved by knowing exactly what amount of fluid each cup/glass in your area holds.
- Does the child’s condition mean they are able to have this fluid? Consider allergies and feeding problems - Is the child nil by mouth.
- Any intravenous fluid must be documented on chart 2 by a registered nurse. Chart 2 fluid balance must be maintained by a registered nurse.

**When to stop**

- **STOP** when fluid balance monitoring is discontinued by senior staff.
- **STOP** and inform nurse of excessive or reduced fluid intake or output.

**Equipment**

- Fluid balance chart and pen
- Measuring jugs or bottles as appropriate

**Procedure**

7. Document the quantity of all intakes in the input column after they have been consumed to ensure accuracy. This includes Oral diet and fluids and enteral feeds given by NG, NJ, PEG, PEJ routes.

8. Document “refused” on the fluid balance chart if the patient declines a Drink and inform a registered nurse if this continues.

9. Identify from the plan of care whether the child is having strict fluid input and output monitoring.

10. If strict fluid output monitoring is not required document when the child has passed urine (PU) or had their bowels open (BO) in the appropriate
column on either chart 1 or chart 2. If a patient has not passed urine, enter “NPU” in the appropriate column and inform a registered nurse.

If the child’s stools are unusual in any way it is helpful to document this alongside the (BO) entry.

If the child vomits this should be documented again in the relevant column along with an estimated volume or indication of size.

11. If strict fluid output monitoring is required urine output should be measured either by encouraging the child to pass urine into a suitable collection vessel. Urinals, bedpans, potties and commodes are available.

This can then be measured and the volume entered in the PU or BO column as applicable.

If the child is in nappies or pads, the output can be measured by weighing the nappy pad and then deducting the weight of the dry nappy. 1g = 1ml of fluid.

If the child is catheterised document the volume drained from the catheter bag at least 4 hourly.

12. If the patient has not passed urine, enter “NPU” in the appropriate column, and inform the child’s registered nurse.

13. Total chart 1 at the end of the 24 hour period as per ward practice including the negative or positive total daily balance. Inform the registered nurse of the fluid balance.

14. Commence a new chart for the following 24 hour period.

Reference

<table>
<thead>
<tr>
<th>Documentation – Fluid Balance Recording</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAME:</strong></td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td><strong>1</strong> Assess whether the fluid is correct for the child.</td>
<td></td>
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</tr>
<tr>
<td><strong>2</strong> Document the quantity of all fluid plus diet in the diet/oral/NG column after they have been consumed.</td>
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<tr>
<td><strong>3</strong> Document &quot;refused&quot; on the fluid balance chart if the patient declines a drink</td>
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<tr>
<td><strong>4.</strong> Identify whether the child requires strict fluid balance monitoring from the care plan.</td>
<td></td>
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<tr>
<td><strong>5</strong> If strict output is not required enter whether the child has passed urine or had bowels open in the appropriate column.</td>
<td></td>
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</tr>
<tr>
<td><strong>6</strong> If strict output is required measure the output in appropriate way and document accordingly.</td>
<td></td>
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</tr>
<tr>
<td><strong>7</strong> Accurately totals charts at end of 24 hour period, recording any negative/positive balance and will commence a new chart.</td>
<td></td>
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</tr>
<tr>
<td><strong>8</strong> Informs nurse of any excessive or reduced fluid intake or output.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sign and date when archived</th>
<th>Signature of Learner</th>
<th>Signature of Assessor</th>
<th>Date of Review</th>
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<tbody>
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</table>
ENVIRONMENT AND EQUIPMENT
PREPARING A BEDSPACE FOLLOWING PATIENT DISCHARGE

Aim
To safely prepare the bed and bed space following movement, transfer or discharge of the patient

Precautions
Infection control guidelines must be followed throughout.

When to Stop
- If you notice damage or soiling to the foam cells in the mattress **STOP** and report to the nurse in charge.
- If you notice any damage to the environment or equipment **STOP** and report to the nurse in charge.

Equipment
- Gloves and apron
- Disinfectant multi surface wipes
- Clean linen
- Linen skip with white bag
- Alginate bag and red laundry bag for infectious/soiled linen
- “Clean bed” sticker

Procedure
1. Wash and dry hands as per Infection Control Policy.
2. Apply gloves and apron.
3. Remove all used bed linen and dispose of in the correct linen skip bag.
4. Check the locker and bed area for any left belongings. If any item is found label and store safely.
5. Remove any rubbish, toys, crockery, signs/notices etc from the bed area.
6. Remove and dispose of any single use equipment.
7. Remove any patient shared equipment, making sure it is cleaned, labelled and stored correctly.
8. Check the environment around the bed area for any signs of damage and report as necessary.

9. Check the condition of the bed curtains and request replacements if needed.

10. Check the bedside chair, including the cushion (unzip and check the underside of the cover and internal foam). STOP if there is any contamination. The item should be discarded and replaced.

11. Check (Unzip the mattress cover and check foam cells for damage or soiling) and clean the mattress, sides, head and the footrest of the bed or cot using disinfectant multi surface wipes.

12. Clean the inside and outside of the locker using disinfectant multi-surface wipes including the patient wash bowl as appropriate. Clean all surfaces of the bedside table and parent bed/chair using disinfectant multi surface wipes. Clean the wall console including the call button and wipe down the patient name board.

13. Check and replace suction and oxygen equipment as required.

14. Check all documents have been removed from the bedside folder, clean and check the condition of the folder and replace if necessary.

15. Clean the floor around the bed area if indicated i.e. visibly soiled, post infection risk. Or inform the domestic to clean the space.

16. Ensure correct disposal of all waste into the appropriate waste bin and empty.

17. Remove gloves & apron then wash and dry hands.

18. Wait for the mattress to dry, and then make up the bed using clean linen.

19. Check all hand soap/hand towels/alcohol gel are replenished.

20. Place clean bed sticker on the bed/locker if applicable. Inform the nurse in charge that the bed is now ready for use.

Reference

**NAME:**

<table>
<thead>
<tr>
<th>PREPARING A BEDSPACE FOLLOWING PATIENT DISCHARGE</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Wash and dry hands as per Infection Control Guidelines. Applies PPE</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>2 Remove all used bed linen and dispose of in the correct linen skip bag.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>3 Check the locker/bed area for any left personal belongings. Remove any rubbish, toys, crockery, signs/notice, equipment and single use equipment. Ensure it is cleaned, labelled and stored correctly.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>4 Check the environment around the bed area for any signs of damage, replace and report as necessary</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>6 Check the condition of the bed curtains and request replacements if needed.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>7 Clean all surfaces carefully with disinfectant wipes. Replace bedding and indicate bed space clean with sticker.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>8 Check and replace suction and oxygen equipment as required.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>9 Check all documents have been removed from the bedside folder</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>Clean the floor around the bed area if indicated i.e. visibly soiled, post infection risk.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>Ensure correct disposal of all waste into the appropriate waste bin and empty.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
</tbody>
</table>

Sign and date when achieved

- Signature of Learner
- Signature of Assessor
- Date of Review

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ENVIRONMENT & EQUIPMENT-
PREPARING A CLINICAL PROCEDURE TROLLEY

Aim
To safely and effectively clean a trolley before and following a clinical procedure.

Precautions
- Follow Control of Substances Hazardous to Health (COSHH) principles
- Follow infection control guideline

Equipment
- Trolley
- Sharps box
- Disinfectant multi surface wipes

When to stop
- If the trolley is not in functional order STOP and inform a registered nurse.
- If the trolley has been used by anyone other than yourself and sharps or contaminated equipment remain on the trolley STOP and discuss with the registered nurse whether it is safe to continue.

Procedure

Prior to the procedure:

17. Wash and dry or gel hands as per infection control guideline. Apply gloves and apron.

18. Collect equipment.

19. Clean the trolley using disinfectant wipes ensuring the top shelf is cleaned first, wiping from side to side from the furthest edge to the nearest edge. Including edges and rims of the trolley. Clean legs down to lower shelf. Repeat sideways wiping action from furthest edge to closest edge of the lower shelf. And then continue down the legs to the wheels.

20. Assist in gathering procedural equipment and place on the lower shelf of the trolley.

After the procedure is completed:

21. Dispose of any sharp or glass object into the sharps bin.

22. Dispose of any single use equipment in the correct clinical waste bin.
23. Rinse and place any items for sterilisation in the SSD returns box.

24. Clean the trolley using the above technique (point 3).

25. Dispose of gloves and apron into clinical waste bin. Wash and dry hands.

26. Return the trolley to the correct storage area.

References


2. Sheffield Children’s NHS Foundation Trust (2016) Control of Substances Hazardous to Health. SCH Corporate Policy (HS790)
<table>
<thead>
<tr>
<th>ENVIRONMENT AND EQUIPMENT- CLEANING A TROLLEY FOLLOWING CLINICAL PROCEDURE</th>
<th>TAUGHT</th>
<th>MODELLED</th>
<th>COMPETENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Wash and dry hands as per infection control guideline.</td>
<td>DATE &amp; SIGN</td>
<td>DATE &amp; SIGN</td>
</tr>
<tr>
<td>2</td>
<td>Clean the trolley using the correct technique.</td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td>Assist in the collection of equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Dispose of any used equipment in the correct clinical waste bin, container and sharps bin as per COSHH policy.</td>
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</tr>
<tr>
<td>5</td>
<td>Return the trolley to the correct location for storage.</td>
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<td></td>
</tr>
</tbody>
</table>

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- Date of Review