THE EDUCATIONAL NEEDS OF QUALIFIED NURSES CARING FOR CHILDREN FOLLOWING TRAUMA.

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Abstract

This study has identified the knowledge, skills and attitudes required by qualified nurses who care for children in Accident and Emergency (A and E) following trauma. These requirements were then compared with the current attributes of such nurses.
The research methodology was carried out in three phases after an extensive survey of the relevant literature. The identification of the level of knowledge, skill and attitudes required for best practice was achieved by the first phase: a Delphi study, being a structured approach to collecting the opinions of a panel of qualified and experienced children's nurses. The actual knowledge, skills and attitudes that nurses have and apply in practice were identified by the second and third phases of the research. Registered nurses caring for children in three A and E units were surveyed by questionnaire whilst further data was obtained by nine sessions of participant observation in three A and E units.

The three sets of results have been compared and contrasted with each other and with the review of the literature and this triangulation approach has led to a number of key findings. The care needs of traumatised children are different from those of adults; at present the majority of children are not cared for by nurses with the necessary competence or within an appropriate environment. Children need holistic care, not just the treatment of their medical injury.

This study has uncovered a specific education and training challenge, because most of the registered nurses in this survey who do care for traumatised children think they are competent in that specific and distinct role, although the observations showed that this is not always the case. Such nurses should be trained in both paediatric and A and E nursing skills. This can and should be achieved by personalised and flexible courses.

The recommendations arising from the key outcomes have been made separately to education and training providers, to the nurses themselves and finally to the health care policy makers and managers who control the clinical environment for the A and E nursing of children's care. The recommendations to the education and training providers are specific to the content of the curricula for training nurses who care for children and to the structure of the corresponding courses. Adult-trained nurses, however expert in that context, are recommended to seek the advice of their child-trained colleagues who care for children. Managers are recommended to benchmark the physical environment, culture and practices of their A and E Units against those in the Children's hospital. They are also recommended to work with education and training providers to support three different models of continuous professional development; models which reflect the different backgrounds and initial levels of competence of nurses who care for children.

The researcher suggests that, if these recommendations are acted upon, then nurses caring for children will be better educated and in turn the practices of caring for traumatised children in A and E will also improve, and will better meet the needs of both the children and their families.

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Glossary

A and E:	Accident and Emergency Departments
Adult Nurse:	A First level grade of nurse educated in general nursing on Part 1 of the UKCC register or trained in adult nursing (project 2000) on part 12 of the UKCC register.
Advocate:	A person who pleads, intercedes, or speaks for another. In this study particularly the child.
Apex Beat:	Apex Heart Beat recorded through a stethoscope
ASC:	Charity: Action for Sick Children
PBLS:	Paediatric Basic Life Support
Child	The "Child" refers to any individual from birth through childhood and adolescent
Child Branch Nurse:	A first level nurse trained in children's nursing (project 2000) on part 15 of the UKCC register.
Children's Hospital Trusts:	Children's Trust Hospital
Children's Charter:	A written grant of rights for children in hospital
Consultant Nurse:	This advanced level of nurse demonstrates professional expertise and clinical leadership skills. Educated to Masters or Doctoral Level
CPR	Cardio-Pulmonary Resuscitation
Culture:	The shared beliefs, values and customs developed by a group of people in adaptation to the physical and social circumstances in which they find themselves.
District General Hospital Trusts:	Local Trust Hospital
DoH:	Department of Health
ENB:	English National Board – Professional Validating Body for Nursing, Midwifery and Health Visiting

Emergency Nurse Practitioner	A specialist nurse practitioner; the specialism being A and E.
Family	Family refers to a group of people related by blood, marriage or adoption who are living together. For the purpose of this study the family relates to the child's significant carers, (who may or may not be the child's natural, adoptive or step parents) siblings and friends.
Family Centred Care:	Where the needs of all of the family members are considered during a child's trauma and illness.
Gillick Competence Theory:	Children under the age of 16 years who are of sufficient understanding and intelligence are considered capable in English law, of giving consent to treatment, even if it is against the wishes of the parents
General Nurse:	A First level grade of nurse educated in general nursing on Part 1 of the UKCC register or trained in adult nursing (project 2000) on part 12 of the UKCC register.
Holistic Care:	Treating the whole person including mental and social factors rather than just the symptoms of the disease or injury.
Homeostasis:	Stable equilibrium of a child's physiological state
Intubation	The introduction of a tube into the larynx to allow air to enter the lungs.
Kinaesthetic Therapy:	Massage and alternative techniques to comfort children during stressful procedures.
Nurse Practitioner:	A competent nurse who exercises clinical judgement and assumes professional responsibility and accountability for the assessment of health needs, planning, delivery and evaluation of routine direct care (DOH 1999a).
Naso-Gastric Tubes:	Plastic catheter inserted via the nose in to the stomach.

PALS:	Paediatric Advanced Life Support
Play Therapy:	A non-directive activity and technique used by children's nurses and trained nursery nurses to allow children to express and deal with their own fears and concerns
RCN:	Royal College of Nursing
RCPCH:	Royal College of Paediatrics and Child Health
Regional Hospital Trusts:	Tertiary Hospital Trust
RSCN:	Registered Sick Children's Nurse (This qualification also includes RN Child). A first level nurse trained in children's nursing on part 8 or 15 of the UKCC register
RTA:	Road Traffic Accident
Specialist Practitioner:	A practitioner who holds a UKCC recordable qualification of specialist practitioner and exercises higher levels of judgement, discretion and decision making in clinical care (UKCC 1998).
Triage:	Assessment of the patient's priority needs for care.
Trauma:	Injury or shock
Urine Catheters:	A catheter inserted directly in to the patient's bladder to obtain urine.

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Chapter 1

INTRODUCTION AND RATIONALE OF THE STUDY

1.1 Introduction

It was the intention for this study to examine the care that children receive when attending Accident and Emergency departments (A and E) in UK hospitals. Children attend A and E in response to both trauma and to sudden childhood illness, but the researcher will only focus upon children attending following trauma. Trauma is defined as experiencing a wound or injury that requires hospital treatment. The aim of the study was to identify the knowledge, skills and attitudes needed by nurses caring for children in A and E units following trauma. It is timely to review the adequacy of the content of current education and training programmes for those specific nurses. The findings from this research will provide a basis for such an analysis. Hence, it will support educationalists in the preparation of programmes to develop highly skilled A and E nurse practitioners working with children.

The idea for this study evolved during a number of years of the researcher's practical experience in the care of children in hospital and latterly in children's nurse education within a university. The particular aims came to fruition following a sabbatical from nursing education when caring for children as a lecturer/nurse practitioner in an A and E department in a District General Hospital. It became apparent that this particular department often ignored the basic needs of children. It did not employ any qualified children's nurses. In the researcher's view, the children themselves received less than an adequate standard of care against the benchmark of the recommendations of many official reports.

Approximately 3 million children attend an A and E department in England and Wales each year (Smith, 1997), with one in five of them attending an A and E department in inner city

areas. As many as 25-33% of the total number of patients attending A and E are under the age of 16 years (Audit Commission 1996) and in some units this rises to over 45% (RCN, 1995a; RCN, 1995b). Muller et al (1992) indicate that, by the age of 5 years, 44% of all children have sustained an injury that requires care and treatment in an A and E department. Because children are more likely to be admitted to hospital in an emergency rather than in a planned way, attendance in A and E is often the first experience, and in many instances the only experience, they have of a hospital environment. Reports have shown that up to the age of 16 years of age children need a service provision within an in-patient area, which is different from that of adults (DoH, 1991; Audit Commission, 1993).

A and E departments are full of distressing sights and sounds (RCN, 1995; Smith 1997; Hogg (ASC),1997; RCPCH, 1999), yet there is little opportunity to prepare a child for this experience. Children have a limited understanding of the strange environments within which they find themselves or of the treatment proposed for them. Almost everything that gave them security is no longer present and they may lack the emotional maturity to cope with these changes. Court (DoH,1976) advocated separate facilities for children in A and E more than twenty years ago. Even today, this is not a reality or indeed a priority in many District General Hospital A and E departments (RCN, 1995b). The frequent lack of child-friendly facilities plus a shortage of qualified children's nurses can often result in children's needs not being met and a diminished quality of care (RCN, 1995b; Smith, 1997; RCPCH, 1999). Qualified children's nurses have been registered since 1919 with the introduction of the Registered Sick Children Nurse (RSCN) qualification. Since 1989 the register for qualified children's nurses has been split into two parts; one part for RSCN and another part for the RN (Child) qualification (Parts 8 and 15 of UKCC Register of Nurses).

A survey of 189 large A and E departments, by paediatric surgeons (BPA, 1995) found that only 15% employed at least one RSCN. Action for Sick Children (Hogg(ASC), 1991) found similar patterns and produced an outline of recommended standards for emergency health services for children and young people. These standards are guidelines for the commissioners and providers of A and E care and hence are a reference point when analysing the results of the study and making recommendations. The degree of provision of facilities for children varies considerably across the UK. A survey in 1995 (RCN Special Interest Group, 1995) found that 18.9% of all A and E departments had no specific facilities for children. Children share waiting facilities and treatment areas with adult patients. Other departments may provide small separate waiting areas but, following triage, (see glossary page xi) many children wait alongside adult patients and then share treatment facilities following assessment by medical staff. Children and young people mainly used these units, with 31% of attendees under 14 years of age and 13% under 5 years. They claimed that the staff were not suitably trained and on occasions did not have the skills to recognise the signs of possible child abuse.

In 1996 there were 15 children's A and E departments in England and Wales (RCN, 1996). Several of these were attached to large Children's Hospitals. Others existed alongside adult A and E services in large District General Hospitals and opening times varied. Some units functioned on a 24 hour basis whilst others only covered an 8 hour or 12 hour time span, operating at peak times for children. Traumatised children attending out of those hours were cared for in an adult department. The Audit Commission (1996) also stated that, even when A and E departments have a treatment room or waiting area specifically for children, they were not always open when required and were not always well used because of staffing difficulties.

The Patient's Charter (DoH, 1996) relating to waiting times in A and E departments, states

that the patient should be seen immediately and treatment assessed promptly by a knowledgeable nurse practitioner. Assessment of the severity of a child's condition and the need for treatment is vital and should be carried out by an experienced children's nurse, particularly because a child's condition can alter and deteriorate much more rapidly than that of an adult (DoH 1991). The Patient's Charter also calls for triage facilities, which ensure the maintenance of confidentiality, privacy and dignity for the individual. Unfortunately, such conditions are often not available and in many instances, children wait in an extremely long queue along with adult patients for their initial assessment and treatment (Smith, 1997). The Health Select Committee for Children's Services in Hospital (HSCCSH, DoH,1997) recommended to the Department of Health (DoH), that regional offices needed to identify and publish target dates by which it expects all health authorities to be purchasing A and E services specifically for children.

One of the reasons why many of the 3 million children attending A and E each year do not see a nurse specially trained to care for children is that there is a national shortage of such nurses (RCN, 1995b; Smith, 1997). Some A and E departments are encouraging qualified A and E nurses to undergo further training to become specifically skilled with children but others are reluctant to do so. The predominant reason does not seem to be financial. Funding is often available to re-train existing staff and to cover the cost of replacement labour. It may be that the specialist knowledge, skill and attitude required for caring for children in A and E is undervalued and regarded as unimportant (Burgin, 1993; RCN, 1995b; Smith, 1997). The Audit Commission (1996) recommended that children should receive care from specifically skilled staff in facilities designed to meet their needs and confirmed that RSCNs are essential but often absent.

Many generally qualified nurses have gained the additional qualification of RSCN in recent years by undertaking an educational programme of at least one-year full-time study. Such a programme prepares them to care for the child's total health care and illness needs. However loosing a nurse for a year to undergo training creates a resource problem for many A and E departments. Furthermore, once qualified as RSCNs, they may be lost to the department as many transfer to paediatric units where their career prospects are often greater (Jones 1996). Hutt (1983) suggested that fewer than 30% dual trained RSCNs found nursing adults attractive. Bentley (1995) suggests that the difficulty in recruiting and retaining children's nurses to A and E units is exacerbated because children's nurses, although having unique knowledge and skills, are often undervalued by their clinical peers and colleagues and by the management.

The Beaumont Report (1996) stimulated the establishment of National Training Organisations (NTOs) for each industry sector. The first NTOs were set up in 1998 and there are now 73 (NTO, 2001). NTOs have the task of identifying current and future skill needs for their specific industry sector and then facilitating work force development programmes. The NTO for the healthcare industry and nursing has not yet focused upon a workforce development programme specific to children's nursing.

1.2: Aims of the Study

The overall purpose of this study is to facilitate improvements to the training of paediatric nurses and to the practice of caring for traumatised children in Accident and Emergency Units in hospitals.

Hence the research aims are:-

- To identify the knowledge, skills and attitudes required for nurses caring for children following trauma.
- To investigate the day-to-day practice, interactions and skills of nurses caring for children following trauma.
- To identify the gap between the requirements identified and actual practice and hence to make recommendations for educational developments and curriculum planning.

The corresponding research questions include: -

- What are the priority needs of children attending A and E?
- Are nurses in A and E aware of the different needs of children compared with adults?
- Are nurses in A and E competent to meet the special needs of children?
- Does this competence affect the quality of care of children in A and E?

1.3 Plan of the Thesis

A Glossary to explain the terminology, particularly that used by the nursing profession, is given immediately after the Table of Contents and List of Appendices.

The next two chapters review the literature about the theories and concepts behind the study and about the nursing care of children following trauma. These are followed by the chapter describing the methodologies of the three phases used for collecting data for the study.

The description of the Delphi technique, (phase 1) will explain how a panel of experienced children's nurses was used to determine the knowledge, attitudes and skills they considered to be appropriate to the nursing care of children in an A and E department.

A questionnaire, (phase 2) was the instrument used to survey the actual knowledge, attitudes

and skills used by the staff in three units caring for children following trauma.

The third phase of the methodology is that of observation by the researcher of actual nursing practices when caring for children in A and E following trauma.

The subsequent three chapters will be the presentation of the results from the three phases of the research methodology. These data, both qualitative and quantitative, are presented in charts, tables and written format.

These data will then be analysed and discussed in detail. The discussion will lead to practical suggestions for the improvement of nursing practice for children in A and E after they have experienced trauma, with the main recommendations intending to focus upon improvements for the education and training of A and E nurses who specialise in the care of traumatised children including the curricula for educational programmes.

Identifying the limitations of this study, summarising the principal conclusions and making recommendations for further research will complete the thesis.

Chapter 2

REVIEW OF THE THEORIES AND CONCEPTS BEHIND THE KNOWLEDGE, SKILLS AND ATTITUDES OF NURSES WHO CARE FOR CHILDREN IN ACCIDENT AND EMERGENCY UNITS.

2.1 Introduction

This chapter reviews the literature regarding theories pertaining to children's needs, with particular attention to children attending A and E departments. Additionally it seeks data in support of the first research objective, viz: -

> To identify the knowledge, skills and attitudes required for nurses caring for children following trauma.

In nursing it is often difficult to differentiate between knowledge and skill and to identify the role of attitude, but for the purposes of this study it was essential for the researcher to attempt to do so. As a first step this chapter will seek literature-based definitions and understandings of the terms.

2.2 Philosophy of Children's Nursing

Philosophy is the study of problems that are usually abstract and very general. They are concerned with the nature of existence, knowledge, morality, reason and human purpose (Teichman 1991). A nursing philosophy is likely to form the foundation for nursing practice and also for the development of a nursing curriculum. It should consist of statements about the key beliefs and values held by the profession. These beliefs and values are likely to be about human beings, health, nursing, and the environment and nurse education. Quinn (1988) believes that philosophy is the most important aspect of the process of a nurse curriculum. A

philosophy for children's nursing must underpin the education and training of such nurses to ensure that they are adequately prepared to deal with the vulnerability of children.

Burrell et al (1988) considered nurse education to be about the business of preparing nurse practitioners to possess specific knowledge as well as preparing them to have certain skills. They consider that knowledge plus skills lead to qualified nurse practitioners being well equipped with principles rather than merely routines and maintain that nurse education curricula should define the philosophy of the educational programme. This in turn needs to reflect the client group. Hence it is important to look at the philosophies which are espoused by statutory and professional bodies in order to meet the standards required for nursing children in particular.

The English National Board (ENB) is the regulating body for nurse education in England and has made recommendations and outlined the requirements for children's nursing education. Central to their view is the provision of holistic family-centred nursing care which relates the developmental stages of each child to the social and cultural influences on both child and family. Their philosophy is supported by a number of reports and policy documents (Audit Commission, 1993; Allitt Inquiry, 1994; DoH, 1991, 1997), which have influenced the direction of children's nursing education.

Article 3 of the second report to the United Nations (DoH, 1999) on the Rights of the Child states:

> "In all actions concerning children, whether undertaken by public or private social welfare institutions or courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration" (Article 3, (Annex) p44).

There is a direct reference to the need for competent staff:

> ... facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff as well as competent supervision" (Article 3, (Annex) p44).

Many reports stress that children who are sick or who need to be cared for in hospital require specifically skilled nurses with different skills and knowledge (Platt Report, 1959; Court Report, 1976; DoH, 1991; Audit Commission, 1993; House of Commons Select Committee 5th report 1997).

The Audit Commission emphasised that nursing children differs from nursing adults in two important respects: firstly the skills such as observation techniques and psychological support which are different to those of adults and secondly the skills for involving parents, (or substitute carers), in care requires specific skills in teaching and support.

2.3 Philosophy of Accident and Emergency Nursing

2.3.1 A and E Nursing

Walsh and Kent, (2001) consider that there are two basic principles for nurses caring for all patients in A and E units. Initially to consider, as a priority, what is in the patient's best interest and also for each individual nurse to ensure that they are adequately trained and prepared for any new roles that can be expected of them. Walsh and Kent also remind A and E nurses that each patient is an individual requiring a full assessment which includes an understanding of their social and cultural background factors at all time. It can be assumed that their recommendations would also apply to children

2.3.2 Children in A and E

Hogg (1997) recognised that training in the special needs of children is a vital ingredient for the success of their care in an A and E unit, with access to that specific care being paramount. She reiterates that frightening and distressing experiences can be detrimental to children, drawing attention to the profound and lasting negative effects of an unpleasant visit to hospital upon children's future attitudes to the health services. Pain that children experience is made worse by fear, misunderstanding and separation from their parents (Atherton 1995).

The RCN (1998b) acknowledge that a family focussed philosophy with corresponding protocols and procedures are essential to the care of children in A and E. Hogg (1997) also gave practical advice to those involved with commissioning emergency services for children: looking at those services from a child's perspective and outlining the standards of care required. That advice was written in the context of the United Nations Convention of the Rights of the Child (1989), which Baum (RCPH, 1999) underlines as an important document for purchasers of care services as well as for the managers and nurses responsible for the delivery of those services.

The Children's Charter (DoH, 1996) was introduced to raise attention to the needs of children, and it gives them the right to have their own views and opinions taken into account. Partridge (1997) suggests that many departments may be in the process of reviewing their paediatric A and E facilities in light of this Charter, but also expressed disappointment that the 1996 Audit Commission recommendations failed to include guidelines for improvement in children's emergency care.

The DoH (1991a) set, as a Standard, that there should be at least two qualified children's nurses (RSCNs or alternatively nurses who have completed the Child Branch of the Diploma or Degree of Higher Education in Nursing) on duty 24 hours a day in all hospital children's departments and wards. They also recommended that a children's nurse should always be available to advise on the nursing of children in other departments. The RCN, in its 1998 response to the Allitt Inquiry following the needless death of many children in one hospital, reinforced the DoH Standard by recommending that medical and nursing staff trained and experienced in the care and treatment of children should be available at all times. The RCN (1994a) advised that staffing levels must be such that A and E departments can function successfully independently of other departments. This is particularly important when looking at A and E units that rely upon staff support from the associated paediatric wards. Investment in qualified staff and the provision of good quality post-registration education results in the delivery of good quality patient care. They acknowledged that children's nurses can and should act as an advocate for the children and their families and are also needed to be a support for non-RSCN staff.

A busy A and E department produces unhappy and unsuitable sights for children; the unfamiliarity, and their pain and bewilderment often making it difficult for the child to understand the situation they are in. Many recommendations have been made for the provision of waiting areas with play facilities and for separate and suitable areas for assessment, examination and treatment of children (DoH, 91, Audit Commission, 93; Hogg, 97; RCN, 99b; RCPH, 99). The Court Report (DoH, 1976) emphasised the need for children's nursing cover to be considered more important in A and E than in any other area. This is particularly valid when remembering that one third of all attendees are children. Hutt (1983) advises A and

E managers to make these positions as attractive and as challenging as possible if children's nurses are to be recruited and retained.

Parents are bombarded with information about potentially life threatening situations but have no knowledge and training to make rational judgements (Philips, 1994). They may over-react to minor problems or under-react to major situations. When parents need treatment for their injured child they require timely and simple access to emergency services. Philips suggests that all A and E personnel, doctors and paramedics, in addition to nurses, should have knowledge which will enable them to recognise and initiate appropriate care to meet the needs of individual children.

In conclusion the philosophy of caring for children in A and E can be summarised by four statements (RCN 1998b).

1. The child is an individual and derives emotional and physical support from his family

2. The child has needs that require assessment and care in a systematic planned approach.

3. The effectiveness of care is influenced by the hospital environments and associated staff who provide it.

4. Good communication is essential for a high level of care.

This conclusion will be adopted as a working philosophy or framework against which to analyse and discuss the nursing practices observed in this study and the knowledge and skills defined and claimed by the Delphi study and the survey of practicing nurses respectively.

2.4 Knowledge and Understanding in Children's Nursing

Perspectives of the nature of knowledge in the literature are mostly generic in their application with knowledge and understanding in the nursing context introduced via limited discussions including the use of phrases such as "know how". The generic perspective will be reviewed briefly before reference to the nursing context.

The Concise Oxford English Dictionary gives non-contextualised definitions of knowledge as

"Knowing, familiarity gained by experience"

"Person's range of information"

"Theoretical or practical understanding of a subject"

"Well-informed"

"Intelligent"

Bloom (1956) in his taxonomy of educational objectives in the cognitive domain defined knowledge as a product which involves the rather elementary skill of recalling or remembering information or experiences. The information may include specific information, terminology or facts. Higher-levels of knowledge involve the ways or means of dealing with such information. The highest level of all includes principles and generalisations as well as theories and structures. These may range from the highly specific and concrete to the more complex and abstract. Walker and Avant (1988) suggest that what is known is not necessarily understood and acknowledge the dictionary definition of knowledge as "theoretical or practical understanding" but add that knowledge is a complete understanding of the sum or range of that which can be perceived or learned. It is this latter definition which will be used in this study.

The above non-contextual definitions, even on layman's terms, do not just comprise facts and information. They include experience and understanding. The knowledge base for nursing as a

discipline or profession must therefore encompass experience and understanding as well as concepts, information and proven fact. Visintainer (1986) states that the definition of a knowledge base for a particular discipline begins with the separation of that knowledge which is important to the discipline from that which is not. This is an interesting concept for discussion when the nursing literature has been reviewed. Perry and Jolly (1991) asked (but did not answer) a further interesting question: who should judge the relative importance of discipline–specific to non-specific knowledge?

Johnson (1968) considers that knowledge can differ in type but not amount; that there is a difference between *knowing that* and *knowing how*, *knowing why* and *knowing what.* Melies (1985) and Benner (1984) agree with Johnson and focus on *"know how"* and *"know that"* in the context of nursing. *"Know how"* consists of practical expertise and skills, for example knowing when a child is deteriorating or knowing how to administer medicine and to build up a therapeutic relationship with a child and family. In contrast, *"know that"* encompasses the theoretical knowledge found in nursing textbooks.

Carper (1978) was one of the first nurses to consider the theory of knowledge in nursing and classifies four inter-related and interdependent types: science, art, ethics and perceptual recognition in nursing (Table 2.1).

Table 2.1: Types of Knowledge in Nursing (Carper 1978)

- Empirics which underpin the science of nursing; describing, explaining and predicting nursing phenomena
- Aesthetics, which is the art of nursing.
- Personal knowledge that relates to the way nurses view themselves and the clients. Although concerned with the therapeutic self, this is the most difficult type of knowledge to master and teach.
- Ethical knowledge. Understanding the differing philosophical positions about what is good, right and wrong. In nurse education, this develops from debate about moral decision-making.
- Graded qualitative distractions made on the perceptual recognition, which might include such examples as judgement of muscle tone in the premature infant or the degree of respiratory distress.

Benner (1984) recognised that practical knowledge may be gained over time and described six areas of practical knowledge that can be observed in expert nurses (See Table 2.2).

Table 2.2 Areas of Practical Knowledge Observed in Expert Nurses (Benner, 1984)

- Common meanings, which are developed by nurses working with common issues such as negotiated care concepts between children's nurses and parents.
- Assumptions and expectations and sets which relate to practical situations where children's nurses have learnt to expect a certain cause of events.
- Paradigm cases and personal knowledge, which are particular cases which stand out in the children's nursing practitioner's mind and which alters the nurse practitioner's subsequent understanding and perceptions of future clinical practice.
- Maxims which are cryptic instructions which only make sense if there is already a deep understanding of the situation.
- Unplanned practices. Benner calls this unplanned delegation or delegation by defaults, whereby children's nurses take on specific tasks and consequently become highly skilled.

Benner remarks that an expert nurse perceives the situation as a whole and that her expertise is based upon many hours of direct patient observation and care. Practical knowledge has much to contribute to the development of nursing theory. Knowledge embedded in clinical expertise is central to the advancement of nursing science.

Children's nurses need to possess knowledge of the Gillick competence theory. The case of Gillick (Gillick v. West Norfolk and Wisbech AHA, 1984) ruled, that, if a minor had sufficient understanding of the nature and consequences of treatment, they should be considered competent to consent without reference to their parents. Nurses in addition to this theory need to have an awareness of the legal implications of the Children Act (1989) (DOH, 1991b). The Gillick competence theory recognises the rights of older children, in A and E, to autonomy and self-determination, providing they have sufficient maturity and understanding to make up their own minds on particular issues. There are three key messages in the Children Act (1989): that the child's needs are paramount, that there should be a philosophy of partnership between the professionals and parents and that there is legal recognition of children's independent rights. Combining the theory and the Act means that children themselves should be given both the knowledge and the opportunity to make decisions, together with their parents and guardians (Hendrick, 1993). If the child is considered competent he or she has the right to make the decision, even if that decision is counter to the views of their parents or guardians. Not surprisingly the interpretation of "competence" in the latter situation is being quite frequently tested in Court.

2.5 Attitudes relating to Children's Nursing

Attitudes are an internal state that influences the choices of personal action made by an individual (Gagné, 1985). Attitudes are learnt as individuals, developing during childhood

and adult life, and predispose an individual to act in a certain way. They are described by Quinn (1989) as having three components: a cognitive component or belief; an affective component or feeling and a motor component or tendency to action. Burrell et al (1988) suggest they are an expression of personal values, learned and fairly consistent reactions towards a person, object or situation.

The United Kingdom Central Council (UKCC) is the regulatory body for nursing, midwifery and health visiting. Its role is to establish and improve standards of nursing in order to serve and protect the public (UKCC, 1997). It has a "Code of Professional Conduct" (UKCC 1984, 1992), which stipulates the actions and attitudes expected of all nurses, midwives and health visitors:

> "Each registered nurse, shall act at all times, in such a manner as to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession". (UKCC, 1984)

Since an attitude pre-disposes the individual to act in a certain way, then the Code can be interpreted as promoting an attitude of "customer care" including awareness of the actions that "justify public trust". Guidelines for professional practice (UKCC, 1996) are given on all of the clauses of the Code. However, guidance specific to the nursing care of children is not given.

The "Scope of Professional Practice" (UKCC, 1992) outlines the individual accountability for each qualified nurse practitioner, and indicates that nurses should refuse to perform activities that they do not possess the competence and confidence to undertake. It applies to all nurses and although the UKCC is not explicit on this point it must, by default, apply also to children's nurses. Although this "Scope" is a direct statement about the actions (or non

actions) appropriate to nurses under certain circumstances it also emphasises the need for nurses to have a positive attitude towards the attainment of personal competence and towards the protection of their patients.

Eighteen years ago Curtis (1983), concluded that children's nurses held the old fashioned attitudes that children could *be seen and not heard* and that RSCN training at that time was becoming an exercise in understanding disease and was, unintentionally, avoiding considering the child as an individual. Curtis recommended that children's nurses have to show common sense combined with insight, warmth, understanding and compassion and that their education should be structured to encompass these qualities. Dingwall and Murray (1983) undertook an ethnographic study of A and E facilities for children and observed how A and E staff labelled patients and made decisions about them based on their compliance or otherwise with their own notion of an "ideal patient". Children appeared to fall automatically into the category of rule breakers, but unlike adult rule breakers, were given priority for care. Dingwall and Murray suggest that this may reflect a wish by the staff to discharge children as soon as possible for the benefit of the staff. Partridge (2001), in her small qualitative study of nurses in A and E, recognised how the fear of looking after children was often manifested by a lack of priority they deserve, "they seem to get shoved to the back".

Burgin (1993), in her qualitative study into the lack of progress of the care of children in A and E, reported that none of the staff she observed and interviewed knew the physiological differences between children and adults. Nevertheless many considered that they could care for children adequately. They displayed poor knowledge relating to the physiological differences of children although she concluded that they were generally treated with kindness and care. An ethnographic experiential study by this researcher (Hall, 1996) was undertaken in an A and E

department in a District General Hospital. That unit did not employ any qualified children's nurses and many of the staff appeared nervous about caring for children. Others enjoyed doing so, but according to them, were not knowledgeable or skilled about that care. There was no formal system to ensure that a *child friendly nurse* was available and used at beneficial times and hence it was "*pot luck*" whether a child received such care.

Hall noted that significant numbers of the children and adolescents who passed through the department had psychological problems. Staff cared well for the trauma needs of children and adolescents but the care for their emotional and psychological needs appeared to be lacking. The attitude of nursing staff towards adolescents caused particular concern. Teenagers were usually sent to adult wards in preference to the adolescent unit, on the assumption that teenagers *"don't want to be with a load of squawking kids"*.

2.6 Concepts of Skill and Competency

A generic definition of skill is *expertness, practical ability and makes a difference* (Concise Oxford Dictionary). Deane and Campbell (1985) point out that practical skills and knowledge lead to expertise, with the ensuing ability to make professional decisions within a team working for the provision of client care.

The Beaumont Report (1996) defined competence as the ability to apply knowledge, understanding and skills in performing to the standards required in employment. This includes solving problems and the ability to meet changing demands. Competence must be demonstrable. Ashworth and Saxton (1990), Ashworth (1992), Hyland (1993) and Shuttleworth (1993) support the measurement approach adopted by the Qualification and Curriculum Authority (QCA). QCA is the quality assurance organisation for a wide range of qualifications

including those that measure competence. Levels of competence and hence the qualifications which are associated with them are determined by QCA accredited Standards of Occupational Competence. These Standards are now available for many industry sectors and have been or are being developed by National Training Organisations in partnership with their associated industry (DfEE, 2000a). Five levels of competence are defined, ranging from that needed by industry for their employees in the most basic jobs up to those who are competent in senior management or senior technically –based functions, for example specifically skilled nursing. Measurement of any particular level of competence leads to recognition via the award of a National or Scottish Vocational Qualification (N/SVQs) at the appropriate level (Gerrish 1997). Occupational Standards for general nursing competencies are only being developed gradually. The continuing debate about specifically skilled children's nursing competencies suggests that the corresponding Standards for children's nurses are even further away.

The measurement of competency in an intellectually based, as distinct from a craft-based, job is the topic of much debate in today's educational arena. All job roles require a framework of knowledge and theory as well as "expertness" and practical ability (DfEE 2000a). It is important to find the correct balance between the amount and level of knowledge and the amount and level of skill that will ensure that a person is competent in a particular job. The categorisation of jobs as either "intellectual" or "craft" is too simplistic in today's technological world. This is increasingly recognised by universities who are organising curricula with skills-development modules in addition to the more conventional knowledge-acquisition components of their courses. Another example of the recognition of need for both knowledge and skills in most jobs today is the latest framework for Modern Apprenticeship (DfEE, 2000b) which involves college-based knowledge modules to complement practical work-based training.

2.7 Skills and Competencies Relating to Children's Nursing

Nursing has traditionally been recognised as a skill-based profession with its intellectual content played down, but the onset of Higher Education and Project 2000 nursing programmes with their combined intellectual and skill content has re-opened debate about the appropriate balance between theory and practice in the context of nursing care. The debate continues about the need for different levels of nursing skills and acquired knowledge and hence competence and about the corresponding need for nursing posts with different grades of seniority. The interpretation of clinical nursing competence can be confusing and contentious (Girot, 1993) and the ability to accurately assess it is problematic (Buckingham, 2000). While (1994) suggested that methods have not yet been found to reliably and accurately evaluate the activities and processes of nursing students. Nursing skill can be characterised by the ability to carry out nursing tasks of two types (Burrell et al 1988). The first type includes intellectual skills such as counselling and interviewing. The second type is craft skills: those that involve psychomotor or manual skills and require training in dexterity and precision.

Chappel and Hager (1994) and Percival et al (1994) commented favourably on a definition of competence from the Australian Nurse Registering Authorities (ANRAC). It is:

> "the ability of a person to fulfil the nursing role effectively and/or expertly. It is an inner, highly differentiated characteristic of a person, which is applicable to the very demanding and very specific context of nursing. It is an ability that effectively encompasses the entire demands of the nursing role, and therefore nursing competence itself posses a complexity that increases with experience and as responsibilities become more intricate".

Benner (1995) suggests a model for nursing competence based upon five levels ranging from Novice to Expert. Her characteristics for each of the five levels are shown in the following table (Table 2.3).

Table 2.3 Benner's Model of Levels of Nursing Skill

Expert
▪ Expert decisions are holistic ▪ Nurse does not rely on guidance or rules to connect understanding of the situation ▪ Enormous background of experience with intuitive grasp ▪ Deep understanding of the total situation ▪ Perceptual acuity and recognitional ability.
Proficient
▪ Perceives situations as wholes and perceives the meaning in long-term goals. ▪ Can recognise when the expected normal picture does not materialise ▪ Improves nurses decision making ▪ Identifies the important aspects and attributes ▪ Considers fewer options and hones in on the key part of the problem ▪ Requires a deep understanding of the situation before maxim used.
Competent
▪ Nurse can see his or her actions in terms of long-range goals or plans of which the nurse is consciously aware. ▪ Lacks speed and flexibility of proficiency but has a feeling of mastery and ability to cope. ▪ Achieve efficiency in organisation
Advanced Beginner
▪ Demonstrates marginally acceptable performance ▪ Aspects are in contrast to measurable parameters but identified through prior experience ▪ Follow instructions and guidelines ▪ Need help in setting priorities as still function on general guidelines ▪ Need preceptors.
Novice
▪ No experience of the situation in which they are expected to perform ▪ Taught about measurable parameters of patients ▪ Rules to guide actions ▪ Following rules is against successful performance as can't direct most relevant tasks to perform in actual situations

It is anticipated that Benner's model of nursing skill will be used as a framework for the assessment of the skills that are observed during this study.

The National Institute for Clinical Excellence (NICE) was established following the government paper "*A First Class Service – Quality in the NHS*" (NHS, 1998). It has the task of establishing an evidence-based framework for clinical services. A key element of that framework will be the ability to demonstrate the clinical competence of nurse practitioners and to support their life long learning.

Day and Basford (1995) described efforts to include NVQs as a measure of competence and hence an additional award to successful students in Diploma programmes of nurse education and found little difficulty in aligning NVQs with the academic level. Le Var (1996) commented that the NVQ related approach to competence assessment leads to a degree of fragmentation, which is detrimental to professional development. Nevertheless, efforts were being made at around that time to award NVQs as recognition of the achievement of standards of occupational competence for general nursing (Gerrish et al 1997). Since then NVQs have been heavily promoted by government via national advertising, including television, and are widely adopted by almost every sector of UK Industry (DfEE, 2000)

Children's nursing is part of the wider profession of nursing. There is a need for nurses to have special skills to care for children (Robertson 1995) in a variety of settings. These specific skills are in addition to the generic abilities required for entry into the nursing profession and are different from the skills needed to care for adults in general or to care for any special needs groups such as the mentally ill. No study has yet identified unambiguously the practical skills the children's nurse should be able to perform at qualification. However, Lawrence (1998) has

commented that an unwritten understanding of these skills appears to exist, formulated over the years by word of mouth from experienced nurse practitioners and lecturers. With that awareness, Lawrence undertook a survey of experienced nurse practitioners to identify the demonstrable practical paediatric nursing skills, which they believed to be essential or desirable at qualification. Seventy four different paediatric nursing skills were identified, 47 of which were believed by a majority to be essential and 25 desirable. Two were undetermined. There was complete agreement that seven skills were essential; these being hand-washing, calculating drug dosages, measuring height and weight, observing and recording pulse, respiratory rate and apex beat, the ward testing of urine and measuring oral temperatures. However, it could be argued that many of these so-called skills were actually tasks and equally applicable to general nursing.

Lawrence did not consider the skills of the nurses working with children in A and E units. It is also important to note that the research of Lawrence is limited to the identification of skills that are of primary importance to the *medical* care of a child. There was no recognition of the value of communication skills or indeed those of play.

The value of communication skills was recognised by Thomas (1992) who highlighted the need for advanced and quick assessment to facilitate the effective triage of paediatric patients. Appropriately trained and experienced nurses can detect potentially life-threatening conditions and determine the priorities of care. Communication may be hampered by the child's stage of development and the subsequent response to injury may be influenced by previous experiences of health care (Hazanski 1992).

Casey (2000) claims that defining professional competencies is complex and difficult but one that needs to be addressed in the future. She defines competencies encompassing motor and cognitive skills that embrace the need to perform clinical actions, make clinical judgements and decisions, and manage information, knowledge and evidence. She suggests that the cognitive skills are the most difficult to define but need to be embraced if children's nurses are to be competent to meet the needs of their clients. She underlines the importance of making clinical decisions and managing information in developing the autonomous and specialist practitioner. The autonomous and specialist practitioner is the concept behind recent references to the role of specialist and consultant nurse practitioners.

Clinical nurse specialist roles have existed since the 1970s. These specialist nurses were seen as experts in a particular area of care, but these titles were never regulated (Castledine 1999). In the 1990s, posts emerged with the title of nurse practitioner, specialising in a wide range of fields and frequently involving nurses performing tasks previously done by doctors. The descriptor for these specialist practitioners was agreed in 1994 (UKCC 1994). The emergency nurse practitioner became such a role and is independent of the present nurse grading system. In A and E the Emergency Nurse Practitioner (ENP) is slowly evolving.

The RCN (1993) has defined the ENP as

> "An A and E nurse with a sound nursing practice base in all aspects of nursing, and with formal post basic education in holistic assessment, in physical diagnosis, in prescription of treatment and in the promotion of health."

Jones and Smith (1998) consider that nurses who are inexperienced in the care of children will find them hard to assess for many reasons. The symptoms of the child may be vague.

Outwardly "normal" signs may be masking a deteriorating condition because of the child's apparent ability to maintain a homeostatic state of compensation for longer periods than adults. They suggest that specialist paediatric A and E departments have great scope for the development and expansion of the role of the "Emergency Nurse Specialist Practitioner" (ENP). There is much literature describing the education and role of ENPs, (Dolan, 1997, Potter, 1990; Robinson, 1993) but few papers discussing the role of paediatric ENPs (Linke, 2000). Kobran and Pearce (1991) and Burgess (1992) drew attention to the potential value of this children's ENP role. Where such ENPs treated 1% of all of the child caseload to conclusion there was a 50% reduction in the time adult patients waited to see a doctor. However, these roles have been slow to develop. Jones (1996) identified a lack of experienced nurses who were able to operate at the appropriate advanced level of practice and decision-making. Reference was made to an A and E department in which only 5% of children were treated to conclusion by staff classified as children's ENPs.

In January 2000 the Health Secretary announced 141 new posts defined as nurse consultants of which 11 were allocated to Accident and Emergency departments (DoH 2000b). However, of those 11 posts, only 2 were allocated to working with children, those being in 2 large children's hospitals. A further 91 nurse consultant posts were announced in June 2000. These are the new top clinical grade for nurses. This is consistent with the proposed career framework for nurses (DoH 1999a), which identified four levels of nurse to be recognised generically as Health Care Assistant at level one to Consultant Practitioner at level four. In the context of this study, the emergency nurse practitioner (ENP) is placed at the third level, identified in the career framework as "Senior Registered Practitioner" (DoH 1999a).

Stillwell (1998) and RCN (1994a) have debated the educational content of ENP training for patients in general (but not for children in particular) and the UKCC (1992) stress that an educational framework for safe practice should underpin these new roles. The need for safe practice is certainly applicable to children. Jones (1996) explains that shortage of training provision is the key reason for the lack of expansion of ENP roles. Jones and Smith (1998) emphasise that ENPs should be regarded as first-rate nurses and not second-rate doctors. Elliott (1999) warns that the medical model prevails in the A and E departments and if nurses are seeking to extend their roles by undertaking medical tasks, it is difficult to see how nursing assessment and nursing care can be valued in the future. She recommends that to overcome the medical philosophy in A and E there is a need for a high profile advocate for children. Linke (2000) proposes an expansion of paediatric ENPs, commenting that although A and E departments have made concentrated efforts to make improvements in their service provision for children, the expansion of such ENPs would be one more step to providing a service that accurately reflected the needs of this client group. However, Elliot (1999) observed that culture inevitably impacts upon practice and the philosophy of A and E is the most difficult to change.

In summary there are two recurring themes relating to the education of children's nurses. First, that caring for children requires specific training and skill and secondly that there is a need for children's nurses to develop themselves from being competent to becoming expert in the context of A and E, with career moves to either a specialist or consultant nurse practitioner.

Chapter 3

CARING FOR CHILDREN FOLLOWING TRAUMA

3.1 Children's Needs

This chapter reviews the literature about the care of traumatised children. First it discusses the basic needs of children and how those needs relate to their stages of development. Then the chapter considers the general needs of children in hospital in the context of that environment and then their specific needs when they are cared for in A and E.

A "need" is expressed, by Woodhead (1990), as an intrinsic natural inner drive. There are different levels of need. Maslow's hierarchy of needs implies that satisfaction of lower needs such as food and warmth are fulfilled before the higher need such as self-actualisation become the priority (Price, 1994). Doyal and Gough (1991) identified two basic human needs as universal; physical health and autonomy. The physical health need is easily recognised for children by health care professionals, according to Price (1994) but the psychosocial needs discussed by Pringle (1980) are seen by Doyal and Gough as the basis for a child's security throughout childhood which in turn supports their need for autonomy.

The way in which children's needs have been met in general has changed considerably since the late nineteenth century. Legislation has either driven or assisted those changes. The Education Act of 1870 made education compulsory for the first time and since then the view of children by society has also changed. They are no longer thought of as being principally financial contributors to society. Today their welfare is a paramount consideration (Children Act, 1989; DoH, 1991b).

A United Nations commission document (DoH, 1999b) recognised that the health needs of children are significantly different from those of adults. Children are vulnerable and hence the provision of effective health services for them must depend upon a thorough understanding of their special needs. The commission recommended that a future strategy for children's services in the National Health Service should be based on promoting fairness, improving the quality of service and promoting partnership and co-operation. Price (1994) comments that, whilst all United Nations commission reports emphasise the special needs of children, they are not explicit. She argues that without the knowledge and understanding of those needs, particularly when children are to be admitted to hospital, it is difficult to conclude whether or not they need the attention of specialist nurses.

The key aims of the UK public health agenda are to improve the health of the population as a whole and particularly that of the most disadvantaged. The basis for any strategic action is the major report *The Health of the Nation* (DoH 1998). This seeks to tackle the root causes of ill health, poverty, unemployment, poor housing and polluted environments. It covers the entire population and therefore must include the health of children and adolescents.

Gay (1991) warns that in order to improve the standards of psychological care of children, the factors contributing to their fear must be fully understood. Children suffer from different specific fears at differing stages of their development. A baby or toddler will react strongly to separation from his/her parents and to the presence of strangers. Adolescents may fear a loss of personal control and will then view care as an intrusion in their developing independence, self-image and identity. Theories which can promote nurse understanding of the child's experience are those of Piaget (1954) and also of Erikson (1980). Both offer explanations for the changes

that occur as a child progresses through life. They comment on the influences that environment and relationships are likely to have on the development process. Piaget (1954), for example, describes the pre-operational stage of a typical two to three year old as a period of egocentrism, that is the child's assumption that everyone sees the world his or her way. Williams (1995) warned that this could lead the child, at this stage of development, to assume that his illness or injury is a punishment. He advises that the nurse should endeavour to dispel this fear and explains that nurses can plan the care that is most likely to be acceptable to a child if they understand how a child is interpreting events and information. Erikson (1980) emphasised the cognitive processes and the drive of children for identity. His theories include how personality structure develops over time as a result of the interactions between the child's inborn drives, needs and responses of the key people in his or her world.

Children have rights, but because they are young they are more likely than adults to have those rights ignored (Leenders, 1996). The United Nations has defined these rights within the document "Convention on the Rights of the Child" (UN, 1991). Its underlying principle is that children are especially vulnerable and have a right to expect special consideration. The message is that in every situation the needs and the voice of the child must be heard and respected.

The need to specifically care for adolescents as well as children is acknowledged by the DoH (1998) and the ENB (1999). Both recognise the role for children's nurses. The ENB underlined the need for adequate care of adolescents during their vulnerable stages of teenage years, particularly in today's society with its increased incidence of substance abuse (drugs, cigarettes, and inhalants) as well as HIV, sexually related diseases and early teenage pregnancies. Suicides as

well as early pregnancies and sexual health issues are of major concern. Self-harm and abuse amongst teenagers is on the increase throughout the western world. This phenomenon is very visible in A and E departments (Hall, 1995) with over-dosing from drugs and alcohol of grave concern. In summary therefore, adolescents, in addition to their susceptibility to accidents, have other needs which both children's nurses and A and E nurses have a duty to address.

Teenage pregnancies are a major problem in the UK. The children's nurse is ideally placed to assist in meeting government targets to reduce such pregnancies because health promotion strategies are a well-established component of their education and training curricula. The DoH (1999a) recognises that offering knowledge based health education to children, including adolescents and their families is an essential part of the A and E nurse's role.

3.2 Children's Needs in Hospital.

Major trauma and serious injuries in children require medical and nursing staff with skills to recognise the need for transference to a specialist unit. Children with a minor injury also need special attention and well managed nursing care (Hogg, 1997). This is because some seemingly minor injuries may be more serious than first envisaged and may well be the result of abuse rather than an accident. These situations require even more skilled and well-managed care by knowledgeable nurse practitioners. However, an injured child is primarily a child first. Care of the injuries in hospital should also be in conjunction with meeting the every day needs that relate to his or her particular level of development (DoH, 1991a).

The Department of Health (1991a) recognised that children need support to achieve their full potential and produced guidelines for their care and treatment in hospital under five main

headings: the contracting of hospital services, delivery of hospital services, other locally provided services, meeting children's special needs, and staff training.

A tragedy, which led to new guidelines to meet the needs of children in hospital, was the case of unqualified children's nurse Beverley Allitt who was found guilty of four murders, three attempted murders and several cases of grievous bodily harm to babies and children in her care in hospital. The "*Allitt Inquiry*" (Clothier, 1994) was established immediately following her trial. The Secretary of State for Health called for immediate action on the resulting recommendations. These were, that district and provider hospitals were advised to have two RSCNs (or nurses who had completed the Child Branch of Project 2000) on duty 24 hours a day in all hospitals children's departments and wards (NHSME 1994). This was to be included within health providers' contracts for the provision and delivery of children's services. The Audit Commission, created in 1983 to audit local authorities and the National Health Service, has produced reports in 1993 and 1996 relating to children's services. Their 1993 report "*Children First*" reviewed hospital services in the context of the DoH (1991a) guidelines and found that many of the conditions were not being met. For example, the need for qualified children's nurses to be on duty all day in all departments and wards was not being satisfied. A survey by Hansard (1994) showed that these recommendations were met by only 57% of hospitals during the daytime shifts. In some cases only one such member of staff was on duty and occasionally none especially during the night. Around 40 hospitals planned to meet the standards by April 1996 (Leenders, 1996). Progress towards this standard has not been reported since then.

A Patient's Charter: "*Services for Children and Young People*" was launched in 1996 to set standards for the delivery of children's services. The Charter includes the statement:-

"Whether your child is nursed on a children's ward or adult ward, you can expect your child to have a qualified children's nurse to be responsible for his or her nursing care. You or your child will be told the nurse's name"

Price (1994) compared the adult experiences of admission into hospital with those of children. She concluded that children do have needs that are different to those of adults in order to cope with their similar experiences, the reason being that children are in a constant state of development. Deciding how these needs are to be met is not simple. According to Price there are two key factors. The first does not involve nurses but the other professionals, particularly the doctor and how they present themselves to the child when prescribing the medical treatment. The second factor requires prioritisation of services to the child to reflect its needs, and collaboration between all of the staff involved. Price concludes that nurses involved in children's care in hospital need to be aware of the child's changing priorities related to the stage of development and the physiological immaturity of the child. She maintains that the knowledge and skill that underpins such awareness is a requisite for nurses if they are to meet the needs of children in hospital.

Physiological variations are present throughout childhood and must be taken into account. They will affect the management of treatments involving medication and dosages; the equipment used and the interventions performed (Burgin, 1995). However the child presents itself the situation is always challenging and there is a need for an accurate assessment of the child to facilitate provision of the best possible care for them and their family. The attitude and approach of the presenting nurse is very important. Staff with competence in communications will influence the rapport, trust and treatment that are both received and perceived by the child and family. Consideration of siblings is also important.

Communication at the correct level for each child is the cornerstone of quality care (RCN, 1998b).

A child's immaturity makes them susceptible to accidental injury. Statistics confirm that accidents are the most common cause of death in children aged over 2 years in England and Wales (Mead and Sibert, 1991). Children's immune systems are still developing and the onset of illness and trauma may be sudden, with children deteriorating rapidly. Extra vigilance is necessary because extremes of heat, fluid and electrolyte loss and infection and tissue injury are not well tolerated (Burgin, 1975).

Children suffering distress in A and E because of invasive procedures require understanding and specialist care to meet their needs (Kurfis Stephens et al (1999). Davies et al (1975) and Stuber et al (1996) explain how such experiences remain upsetting in a child's memories for many years. Kurfis-Stephens recognises how kinaesthetic non-pharmacological therapies such as distraction stroking, singing, talking, visual and interactive distraction give comfort to children under 5 years. This can be accomplished by nurses, nursery nurses (play therapists) or by involving the parents, who at present can often be whisked away by medical staff.

Many nursery nurses employed as play therapists in hospital wards and departments, provide an invaluable resource for children through play. Play has a special significance in A and E in that it allows children to cope with the particular stresses and problems arising from their injuries. Many nursery nurses have undertaken a post-qualifying specialist course to become qualified hospital play therapists (Barnes 2000)

Twycross (1998) discusses how pain is an individual and subjective phenomenon, with individuals, especially professionals, having their own perceptions about it. Carter (1994) explains how pain is a unique and complicated experience for children and infants that is difficult for them to explain to adults. Davitz and Davitz (1981) and Mason (1981) said that nurses at that time believed that children might have the same pain as adults but that they believed it caused them less psychological distress. Neither study indicated whether or not the nurses involved were specifically educated to be children's nurses. McCaffery (1972) warns that frequent exposure to painful stimuli does not desensitise the child but rather increases that sensitivity to pain. This is supported by Gildea and Quick (1977) who reported that a child who has had injections in the past does not become used to them but shows more anxiety and complains of more pain. Beyers and Beyers (1985) suggested that nurses rely on intuitions, assumptions and personal beliefs to assess children's pain which may result in it being under estimated. More recent research supports this (Manne et al 1992; Romsing et al 1996; and Woodgate and Kristjanson, 1996).

Twycross (1998) suggests that many nurses keep children's pain at a tolerable level but are not consistent in their assessment and management of it. The possibility that pain relief is a low priority is supported by the research of Abu-Saad (1984) and Burokas (1985). Woodgate and Kristjanson report that nurses concentrate on the technical aspects of care rather than assessing children's pain. Carter (1994) maintains that effective pain management starts with a commitment to believe in children's reported pain followed by the responsibility to work with the child and family to achieve the best level of pain control. She believes that pain management is based upon honesty and trust alongside effective communication skills and warns that, without the skills of good communication, pain management is likely to be seriously flawed. She offers a selection of child friendly communication pain assessment tools.

Ellis (1998) supports the use of pain measurement tools with children, whilst observing that the use of such tools has demonstrated that nurses' perceptions of children's pain is not always accurate.

Twycross (1998) advises that nurses need education to be aware of the factors that influence their individual assessments of pain and need to be made aware of the influences on their own perception of pain. She recognises that changing practice is not easy but that they need to become more accountable for the management of pain in children.

It is essential to consider the cultural needs of ethnic minority groups, respecting their values and attitudes to childcare and health. Slater (1993) identified a failing in nurses to recognise the ethnic needs of children and their families, ethnicity being an important area of their lives. Whiting (1999) states that culturally sensitive care is not always provided for children and their families and observed that although suggestions for improved practice have been made, there are no finite answers. According to Papadopoulos et al (1998) nurse education is failing to prepare students to address the needs of our culturally diverse society. The code of professional conduct requires all nurses to recognise, respect and respond to each child, taking into account influencing factors such as ethnic and religious needs. Whiting (1999) proposes four key areas of study; to find out if children's nurses and families view cultural awareness as a priority; the value of integrating a stronger cultural awareness theme into children's nurse education programmes; the need for children's nurses to cherish the philosophy of family-centred care and the need for a multi-professional approach to cultural awareness. Slater recommends that all nurses caring for children in hospital should take in to account the ethnicity of the child and family when assessing and managing their care.

Walsh and Kent (2001) point out that, in A and E, both nurse and patient need to look at the same problem in the same way. The patient's perspective, because of his or her social and cultural background, for example class, age, religion and ethnicity, may be very different from that of the nurse. An open minded, non-judgemental attitude on the part of the nurse is needed to bridge what might be a very wide gap between nurse and patient.

3.3 Child Friendly Environments

Smith (1997) advocates that children should be protected from the distressing sights and sounds of sick and injured or drunk adults who are verbally or physically abusive. Dyke (1998), witnessing violence against staff by patients in A and E, was unable to make any meaningful recommendations, suggesting that these attacks are as a result of mental illness, drug or alcohol abuse. There was no mention in his report how this might impact upon children. Smith emphasises the need for children and their families to be cared for within a suitably friendly and safe environment by staff trained to meet their special needs, as young children have a limited understanding of the strange environment within which they find themselves.

Heptinstall (1996) states that it is common for parents and children, in her study, to have to wait for several hours after the initial assessment in overcrowded and unsuitable waiting rooms. A lack of information and broken or dirty toys often exacerbated that length of time waiting. Her study shows that many Units lack books or magazines to keep older children, adolescents and parents occupied during such delays.

Children differ from adults in more respects than size alone. Up to the age of 16 years is a period of great change (Bee, 1995). When the strange environments of an A and E department confront children they have no understanding and may suffer severe psychological trauma

unless cared for with sensitivity (DoH, 1991a; Audit Commission, 1993; Smith, 1997). Comfort, reassurance and the constant anticipation and interpretation of their inarticulate needs are essential at such times and they benefit from the constant company and attention of their family. Some children may appear only mildly apprehensive but for others the experience is desperately unhappy and frightening (Smith, 1997). The child may present screaming and uncooperative or alternatively be quiet, withdrawn and unhappy according to Lanning (1985).

The knowledge and understanding that children have reflects their age, social background and culture as well as their past experiences. Their nervousness and bewilderment about being in A and E is more marked if the child has visited the department before. Vistainer and Wolfer (1975) identified five causes of great concern for children who are being admitted to hospital. They fear physical harm and separation (prime causes of distress) and fear of the unknown, uncertainty about their situation and loss of personal control. Smith (1997) reports that the degree of provision varies considerably across the UK and even though some departments provide separate facilities for children they are not always open and are not well used as a result of staffing difficulties. Six years ago, the British Paediatric Association (1995) reported there was no paediatric A and E Medical Consultant in Yorkshire with only 6 in the whole of the UK. They comment how medical staff that have not had child specific training are not usually able to act or even think about acting as advocates for children. Advocacy is an appropriate A and E role for the qualified children's nurse.

3.4 Meeting Children's Needs in A and E

Elliott (1999) maintains that adequate assessment of children depends upon the environment, culture of the department and the ability and communication skills of the staff. Webb and Cleaver (1991) strongly believe in the importance of children's nurses in A and E and suggest

that the priorities of A and E nurses are often incompatible with the care of children. Lenehan (1988) recognised the need for appropriately educated and experienced nurses to perform triage when a child is involved. Nurse managers in A and E in the Unites States of America stress that the margin of error with children is much narrower than that with adults in areas such as changes in physical status and drug dosages, all of which are age and /or size dependent (Lenehan, 1988).

Hanton (1981) underlines the link between children's care and the word "special" and suggests that qualified paediatric nurses will not only have gained additional expertise in the use of selected paediatric equipment but should also appreciate the needs of infants and their parents. She comments that children are often cared for in highly skilled and specialist adult units with technical excellence but they receive a *scaled down* treatment due to *scaled down* adult status. Children's nurses should be aware of normal and abnormal development and patterns of behaviour and can then assess child-parent reactions effectively (Hanton, 1981). They should be involved with the whole family unit with knowledge extending to encompass the psychosocial aspects of the child and family reaction to hospitalisation.

Hanton went on to explain that children's nurses usually have a general love of children mixed with a deep sense of humour and should also have confidence to provide the necessary support for the children and their parents and siblings. They need to have reached a good standard of theoretical work with a detailed knowledge of the normal development of children so as to always understand their needs. She further argues that such nurses will appreciate the importance of play activities and the provision of play material, play leaders and playful environments.

Bentley (1996) said that the majority of children are still seen in general A and E departments and then studied the extent and nature of such services and facilities for children. She paid particular attention to staffing and the role of the children's nurse. Respondents to her study of 153 A and E units in the UK estimated that children made up to 25% of their clientele (although only 11% of those units were able to give accurate statistics). However it was accurately reported that only 49% employed a qualified children's nurse, with a high proportion employing only one. Watson (2000) suggests it is difficult to estimate the impact of one or two individual children's trained nurses working 37.5 hours per week. It could be viewed as a token impact upon the quality of childcare. Watson also noted that, even when children's nurses were employed in A and E, they are not necessarily caring for children. Bentley (1995) highlighted the difficulty that A and E departments have in recruiting children's nurses, suspecting tokenism and expressing concern that those who were employed in A and E were on lower grades than those (equally qualified and experienced) working on hospital wards. A and E managers apparently justify this as due to the lack of A and E experience of children's nurses.

Bentley (1996) suggested that the role of the children's nurse fits into three main categories: to assess and treat children, to be advocates for children and finally to be an educational resource, disseminating information regarding paediatric issues, health promotion and supporting the education of students. On the other hand, Watson (2000) questions the role of the children's nurse and whether there is any measure of the contribution made by them to A and E.

Stammers and Chippendale (1995) report that many general nurses, employed in A and E, have a lower skill and knowledge level when dealing with children in A and E than Child Branch students, and subsequently have difficulties teaching students quality child-centred, emergency

care techniques. The aim is for all nurses to provide high quality care to all client groups including ensuring that student nurses are given the best possible experiences and education; Stammers and Chippendale maintain that A and E departments should specifically aim to increase the A and E skills of qualified children's nurses.

Davies (1995) explored parent's perceptions of quality of care and highlighted areas of dissatisfaction. These included staff negative attitudes (such things as not speaking to the child) with no attempt to instigate a rapport with the child. Heptinstall (1996) received views from children following trauma care in A and E and concluded that 79% of the children surveyed were distressed immediately following an accident, however, most of these children hid their distress so as not to worry others, especially their parents. She encourages staff to communicate closely with children and their parents (carers) and discovered that whilst it was common for A and E departments to provide parents with written advice on the physical symptoms to expect as a result of their trauma, very few had leaflets advising parents on the emotional effects of accidents.

3.5 Communicating with Children

Kitching (1998) points out that although the Children Act (1989) gave the child a voice, if a child in hospital fails to conform to popular opinion then those in a position of assumed power will overrule the child. A major hurdle to empowering children, according to Kitching, is the barriers that exist when professionals avoid opening up areas for which they have no answers or where they lack the skills to draw out a child's thoughts and feelings.

Empowering children to make informed decisions may seem utopian but children do have basic human rights that need to be met and not ignored through incompetence. Kitching

believes that the message that "adults know best" remains dominant in both institutional and domestic settings and that there is a need for front line caring nurses to turn rhetoric into reality. Morton and Phillips (1992) analysed the skills required by the nurse caring for a pre-school child in A and E, focussing upon the importance of communication. Wood (1997) argues that to communicate effectively with children, nurses must not only be competent in their use of language but must also be skilled in the context in which it is used. Wood suggests it is not simply verbal communication; non-verbal issues also need to be addressed. Careful listening and observation, avoidance of interference and reflection with the use of questioning are all highlighted as indicators of good practice. Empathy and taking the other person's point of view is fundamental to communication with the principle of respect for the child and their needs being imperative (Petrie, 1989). Long (1991) discusses the non verbal skills required by children's nurses with the need for them to be aware of how they are viewed by children. Hargie et al (1994) indicate that the outcome of their interactions with a child and its family will depend upon the knowledge, motives, values, emotions, attitudes, expectations and dispositions of those involved. Wood suggests that these factors will determine why some A and E nurses seem to be more comfortable and natural than their colleagues when dealing with children. He debates Perry's (1994) statement that communicating with pre-school children is inevitably a lengthy procedure and that such time consuming communications is not an effective use of busy A and E nurses. He concludes that the time consumption needs to be weighed against the benefit of the child receiving high quality care.

3.6 Partnership in Care

Since the publication of the Platt Report (1959) on the welfare of children in hospital there has been increasing interest amongst parents and policy makers about how health care professionals might "humanise" the experience of hospital for children and their families. The

Platt Report had stressed the importance of open visiting but progress in implementing the recommendations has been slow and rather narrow in vision and naive in expectation (Darbyshire 1994). Darbyshire said that the efforts until then had concentrated upon encouraging parents to live in with their child during hospital stays. The idea of partnership in care was at the level of official and professional ideology rather than in every day practice.

The concept of family centred care had been earlier promoted by the Children Act (1989), the Department of Health (1991) and the Audit Commission (1993) and then confirmed by the DoH in 1997. The family (or carer) should be central to the plan of care for any child visiting hospital (Dolan 1997) because the family is central to the child's life.

Darbyshire (1994) concluded that parent participation is one of paediatric nursing's most amorphous and ill-described concepts. Until 1969, involvement centred on parents performing tasks in order to feel useful to their child and to the hospital (Meadows, 1969). Meadows, a paediatrician, went on to propose that nurses be trained to share care with mothers. Darbyshire advised that family centred care extends further than technical or task-centred paediatric nursing care. He developed ideas around the conceptualisation of family power and surveillance and the nature of the nurse-parent relationship. Nurses caring for children should not limit parents to being simply helpers or performers of tasks. They should not consider parenting in hospital as just being a series of discreet childcare activities. He conveyed the notion of listening to parents and believes that nurses have a lot to learn from parents before presuming to teach them.

Old practices die hard. Historically, children admitted to hospital were only allowed to be visited by their parents for one planned half hour per day (Duncomme, 1951). However,

paediatric philosophies have changed considerably since 1951 and influential work on maternal deprivation (Bowlby, 1973) accelerated the care of hospitalised children without unnecessary separation from their family. The work of Robertson (1970) and Hawthorne (1974) also had a major impact on reuniting parents with their hospitalised child.

A parent's group, the National Association for the Welfare of Children in Hospital (NAWCH – now known as Action for Sick Children, ASC), formed around 1970 has made a major contribution to the pressure to implement the Platt Report, but even today, this researcher observes, many children are still being cared for in the adult areas of a hospital, in the wards and particularly in A and E.

Webb and Cleaver (1991) strongly believed in the importance of qualified children's nurses in A and E and suggested that the concerns of specialist A and E nurses are often incompatible with the care of children. Hence there is a need to actively promote a child and family centred philosophy in such an environment. However, Dolan (1997) argued that such an action may well anger A and E nurses and does seem rather unfair in its assumption that their interest and capability is limited to emergency situations. It is interesting to note that Dolan is herself an A and E nurse but not a qualified children's nurse. Her views are potentially an uncomfortable fit with the partnership philosophy for the care of children.

Coyne (1996) defined three aspects of partnership in care in a ward setting; negotiation and equality of care, parents as equal partners and shifting the responsibility of care to parents. Lee (1999) discussed the concept of partnership nursing in an A and E setting and what this might mean to children's nurses, believing that it is an elusive and qualitative subject. Through a concept analysis framework, similar to that of Darbyshire (1994), she proposed that children's nurses should advocate partnership as the underpinning philosophy when caring for children

in any setting including A and E. She acknowledged that such a philosophy may not be familiar to the majority of staff in A and E and that resistance can be expected from them, but that unfamiliarity should not be allowed to prevent implementation when the child and family would benefit. Lee (1999) suggests that it is important to gather the perceptions of the child and family rather than assume, as Kawik (1996) appears to have done, that nurse and family perceptions correspond with each other. Callery and Smith (1991) warn that not all innovations are considered ideal by families and indeed, for some, there can be a downside. Coyne (1995) and Darbyshire (1994) point out that, too often, assumptions are made about family wishes regarding involvement in the care of their child. Coyne suggests that an accurate assessment of parents' expectations and abilities is essential to partnership planning. Inexperienced nursing staff tend to discourage family involvement and parental participation. Darbyshire commented that family-centred care cannot be ordered and only after open discussion between family and nurse can acceptable proposals and agreement be made.

Coyne (1996) found that nurses tend to decide the amount and type of participation that parents should undertake in the care of their child. Nurses will assume, for example, that parents are comfortable to undertake administration of medicines or support their child during suturing when in fact they would welcome the opportunity to give that responsibility to someone else. Such assumptions leave parents with little opportunity to disagree and can lead to the feelings of guilt (Darbyshire 1994).

Valentine (1998) observed that junior nursing staff appear to lack the skills to translate the theory of family centred care into everyday practice. Her qualitative study of a sample group of ten children's nurses, ranging from staff nurses grade D to senior nurse specialists, explored the concept of family empowerment from a children's nurse perspective. She obtained details

about their perceptions, attitudes and beliefs and about their practice of family empowerment. Most of the nurses in her study identified the skills they needed to work successfully in partnership with children and families as good communications, teaching, supervision and assessment of families. The senior nurses also offered as essential the skill of good judgement combined with the personal qualities of confidence. Valentine found that the senior nurses had a more positive attitude towards parent empowerment. They considered it essential and thought that parents should be given the power to act as true advocates for their child and subsequently to enforce what their child wants. The less experienced children's nurses in Valentine's study had reservations about parents participating in their child's care. They described feelings of being personally threatened and difficulty in dealing with assertive and demanding parents. They described being " *stripped of their roles*", of "*losing their practical skills*" and "*having to cope with criticism by parents*". Valentine concluded that junior nurses need much more supervision and support by senior colleagues in their role development.

Lee (1999) advises caution. Research is needed to ensure that families are not being disadvantaged by the application of parental involvement in care. She recommends monitoring parental satisfaction and makes the interesting point that parent's expectations in the A and E setting may be found to differ from those of parents on children's wards. The responsibility for care is quite different in the two settings.

3.7 Child Protection

Powell (1991) recommends child protection as one of the specific areas for extra training for staff dealing with children in A and E. Nurses working with child protection, whatever their qualifications, are likely to find that making a decision with respect to child protection is one of their most challenging experiences. The DoH (1988), following the Cleveland Inquiry (1988)

into child abuse recommended all nurses to work within a framework of child protection and local policies and with close adherence to procedures. Smith (1992) argued that action must be taken to bridge the theory-practice gap and Behi and Nolan (1995) warned that trial and error is often the only way staff obtain the practical knowledge and skills needed to deal with these child protection issues.

Hall (1995) listed the significant factors which relate to non-accidental investigation, but reported a lack of recognition of them by A and E staff. The significant factors included that all of the nurses caring for babies, children and adolescents in A and E were adult trained nurses. Almost half of the respondents in her survey did not know who their named nurse for child protection was and less than one quarter had received any formal education and training in child protection or about the Children Act (1989). Hall concluded that, not surprisingly, the majority of nurses expressed a feeling of not being adequately prepared. Two thirds of the nurses in Hall's survey had not changed any of their practice with children since the implementation of the Children Act (1989) in 1991, with 85% expressing a need for further knowledge relating to child protection.

Fagan (1998) discusses the role of child protection for A and E nurses, noting that in such environments they need to develop an informed and heightened awareness of the indications of child abuse. She recommends that such nurses must have a confident grasp of the correct procedures to be followed and that they also should have a working knowledge of the availability of supporting multi-disciplinary resources. Fagan was unable to identify the knowledge that A and E nurses have (or do not have) about child abuse and child protection. Nor was there information about what they actually do in practice when faced with this situation. She questioned fourteen A and E nurses and found that their experience of nursing

children with suspected abuse was significant. It is evident that A and E nurses are in a prime position to pick up on non-accidental injuries. However ten did not perceive themselves as being skilled because they do not experience abuse cases on a regular basis. Fagan did not indicate whether or not any of her nurse samples had children's nursing qualifications.

One in four children suffer from abuse (DoH, 2000a) and Powell (1997) suggests that junior doctors generally have less experience in identifying and responding to signs of child abuse and neglect than experienced nurses. Jezierski (1994) found that 22 - 35% of women seeking A and E treatments for any complaint attended as a result of domestic violence. There is evidence that domestic violence towards women and abuse of children are often linked (DoH, 1999). Davies and Edwards (1999) discussed the role of A and E nurses and highlighted the need for vigilance when working with both women and children who have suffered injuries from domestic situations.

Today, professionals involved with child protection acknowledge the close link between domestic violence and child abuse. But at the moment policies and procedures for suspected child abuse are different from those for the protection of women. Davies and Edwards suggest that they should be linked and indicate the need for vigilance and referral. The Government has accepted that A and E nurses have a role to play in supporting women with injury as a result of domestic violence (DoH, 2000a) but so far have failed to act upon the importance of protecting children in such scenarios.

3.8 Developments in Children's Nursing

Recognition that children are not "just small adults" was further supported by the decision to develop the Project 2000 child branch education and training programmes (ENB, 2000) which

continues the UK tradition of having first level registration qualifications specific to children's nurses. However, the ENB, UKCC or indeed the nursing profession has not yet resolved the generic versus children's nurse specialist debate. There is an ongoing debate about the best way to educate and train nurses to care for children (Whiting et al 2001). The question that is now being raised is whether or not the Child Branch qualification should be replaced by a second level post-registration qualification to be undertaken by those nurses who wish to become children's nurses.

The 1994 UKCC document "*Standards for Post Registration Education and Practice*" (PREP) outlines the need for post qualifying education for nurses in general. The need for specific training for qualified children's nurses in A and E departments has now been recognised by the Department of Health (DoH 1997), the Royal College of Nursing (RCN 1998b) and the English National Board (ENB 2000).

Until recently the normal post-registration programme to become a children's nurse was for Registered General Nurses to re-train to become Registered Sick Children's Nurses by undertaking either a six-month or fifteen-month programme, the length of the programme being dependent upon the individual experiences. An eighteenth month child branch programmes has now replaced these. The guidelines relating to conversion from RGN and registration in Part 8 of the Professional Register of Nursing have been superceded and are not now generally available (ENB, 2000). The ENB states that qualified general nurses may undertake a Diploma of Higher Education (Child Health), but this must be a minimum of twelve months in length and undertaken in the appropriate branch programme. To date no written statement about shortened nursing diploma programmes, but the ENB (1999a) is

working towards other opportunities for general nurses to acquire children's nursing qualifications.

The English National Board currently validates most of the programmes of education and training of nursing professionals, although it is to be replaced by a new government funded Central Council (NHS Executive 2000) with a structure still to be finalised. They presently recommend the indicative content in general terms that can be adapted to suit the individual student's needs. However, the ENB have been reluctant to validate many of the childcare short courses available in a number of Universities. Such a course may, for example, be twelve half days spread over a period of three months. It is questionable whether these short courses can by themselves develop adequate knowledge. Yet, for practical and economic reasons, managers of hospital units could send staff on these short courses instead of supporting their staff in becoming fully qualified. Unrecorded discussion at recent conferences suggests that this reluctance by the children's nursing profession, including the ENB, to validate these short courses appears to be due to the concern that nurse managers will use this opportunity to avoid supporting their own staff to become fully qualified.

In response to the request of NHS Trusts in SE London, the Nursing Institute of the RCN established a paediatric course for A and E nurses at Post-registration level. Others followed around the London area. These courses tend to last for about seventeen weeks and reflect the unique developmental, anatomical and psychological stages of childhood. Planned further developments are to incorporate distance learning into the curriculum, which is being organised at degree level. These courses, unlike the short courses referred to earlier have been recognised by the ENB.

In summary, children are especially vulnerable and their needs in hospital are different from those of adults and require special consideration. A physical environment which is acceptable to an adult is unlikely to be suitable for children. In A and E they need to be cared for by a children's nurse qualified to understand their special needs and able to communicate effectively with both the children and their supportive families whilst being alert to signs of child abuse. The curricula for qualifying children's nurses vary in detailed content depending upon the actual educational establishment, but a common need is to include A and E training. The movement towards modular programmes within Higher Education and the general trend towards standards of occupational competence all underline that it is timely to review and upgrade post registration educational nursing programmes to meet the needs of children and their parents attending A and E departments.

Chapter 4.

ETHICAL CONSIDERATIONS

This chapter explains the ethical considerations which were taken into account in the study at the planning stage of this research, and subsequently as it was carried out. The first part of the chapter reviews the literature relating to the ethical considerations that should be taken into account when carrying out qualitative research. An appropriate framework was identified. This framework and the Nurses Professional Code of Conduct (UKCC, 1992) influenced both the design and the execution of the study.

Miles and Huberman (1994) assert that all research, and particularly qualitative research, needs to consider the accompanying ethical principles. Robson (1993) maintains that participants in research may be involved in ethical dilemmas without their knowledge and could be misled about the true nature of the study. The researcher's "right to know" needs to be balanced against the rights of the participants, and in particular to their privacy, dignity and self-determination. In this scenario the researcher often needs to act as both judge and jury. Robson also advises that participants might be forced into situations that create stress and anxieties for them, thus underlining the need to avoid deceptions that create conflict.

Flinders (1992) suggested that many approaches to qualitative research in any field can be explained by a model including the framework theories of utilitarianism, deontology; relational and ecological ethics. This model is presented in Table 4.1.

Table 4.1 : Ethical Frameworks and Aspects of Qualitative Research (Flinders, 1992)

Aspects	Utilitarianism	Deontological	Relational	Ecological
Recruitment	Informed Consent	Reciprocity	Collaboration	Cultural Society
Fieldwork	Avoidance of Harm	Avoidance of Wrong	Avoidance of Imposition	Avoidance of Detachment
Reporting	Confidentiality	Fairness	Confirmation	Responsive Communication

Utilitarianism judges actions by their specific consequences, for example the benefits and associated costs for the various groups of people involved in the research (Miles and Huberman, 1994). A utilitarian judgement for this research is the ability to recruit individuals to the staff survey and to the Delphi panel via a process of informed consent. The observational study also needed a utilitarian approach, to ensure that no harm was caused to staff or patients in the clinical areas or via the notes that were taken. Deontology is more absolute, with the considerations in this study being avoidance of wronging others and making reports just, fair and honest. The relational approach stresses the need for collaboration whereby the researcher and the researched are on an equal status. The practical interpretation for this research is that the report is in the interest of all and should benefit all without undue imposition. Flinders suggests that an ecological view of ethics leads to the researcher to be sensitive to language and culture so as to avoid detachment from any wrong or harm that may be discovered. Should any wrong be observed in this study, it is the intention to be honest and explicit but yet sensitive in its communication.

House (1990) discussed the three basic ethical principles of mutual respect, non-coercion and non-manipulation and the support for democratic values during such research as this study.

The main theoretical aspects to be considered by nurse researchers according to Polit and Hungler (1994) are beneficence or "doing good". The beneficent need for this research was to maximise the good outcomes in the interest of children whilst at the same time minimising the harm that was encountered en route. An example was minimising the likelihood of a drug error by being a participant as well as observer in the research. Polit and Hungler also recommend the need to respect human dignity and justice. Beauchamp and Childress (1989) had already recognised the importance of beneficence and justice and also drew attention to non-maleficence (doing no deliberate wrong) and respect for autonomy. These were all considerations for this research during the process of its design.

Real-life ethical dilemmas are familiar to the researcher from her clinical experience and all registered nurses are required to practice within a "Code of Professional Conduct" (UKCC 1992). This code has been supplemented by a booklet which is a guide for reflection of the statements within the code and is intended to help nurses "care" in a way that reflects that code and its implicit standards of professional conduct (UKCC 1996). This study has been related to include the ethical and moral considerations within the Code and the guidelines in the following table (Table 4.2) to ensure the maintenance of professional standards.

Table 4.2: Ethical and Moral Considerations for this Study

Professional Code of Practice	Relation to Research Study
Act always in such a way as to promote and safeguard the well being and interests of patients and clients	Applicable to children and their families in A and E.
Ensure that no action or omission is detrimental to the condition of the patient or client.	Need to ensure that no action or omission is detrimental to the child and family during the participant observations.
Acknowledge any limitations of competence and refuse in such cases to accept delegated functions	During participant observations, ensure that no delegated practice is undertaken which the researcher does not consider herself to be competent to undertake.
Take into account the customs, values and spiritual beliefs of patients.	Recognise the ethnicity needs of the child and family as well as the culture of the staff and the environment.
Respect confidential information obtained in the course of professional practice.	Ensure that confidentiality is maintained throughout the study and make no reference to individuals who might be recognised. For example the participant Units and staff within them will not be identified in the report.

This research was designed, taking into account the considerations in Table 4.2 and an awareness of the important issues for children's nursing of informed consent, confidentiality, autonomy, justice, honesty and "doing no harm". The design model was an expanded version of Flinders ethical framework of 1992 and is illustrated in Table 4.3. The ethical issues for consideration are highlighted by the shaded areas. The ethical aspects described in Table 4.3 include the stage at which they needed to be considered, that of recruitment to the Delphi panel and staff survey, in addition to the phase of the participant observations (field work) and finally when reporting the results.

Table 4.3 Implementation of Flinders' Framework

Aspects of Research	Utilitarianism	Deontological	Relational	Ecological
Informed consent during recruiting and fieldwork.				
Honesty, justice and respect during recruiting and fieldwork.				
Unnecessary harm to staff respondents or child participants during fieldwork.				
Sensitivity and diplomacy during recruitment and fieldwork.				
Observation of the rights of children during fieldwork				
Privacy, confidentiality and anonymity during recruiting, fieldwork and reporting.				
Vulnerability of staff, children and their families during fieldwork.				
Protection of identity during reporting.				
Role conflict during fieldwork.				
Intervention and advocacy during fieldwork.				
Response to distress during fieldwork.				
Research integrity and quality when reporting.				

Van Maanen (1979) noted that field workers may often "penetrate fronts", in that participants are to a degree, coaxed, persuaded, pushed, pressured and often blackmailed into providing information which they might otherwise prefer to shield. Thus this research will not be conducted in a manner that will knowingly push any sensitive or difficult matters. Embarrassing scenes will be reviewed as they arise, with a possible decision to leave such a scene. Smith (1992) points out that "investigative research" could involve deception and Deyhle et al (1992) warns that observers "might project a fake persona to gain knowledge and access to situations". The researcher intends to enter all relationships with integrity and honesty.

McCall and Simmons (1969) caution that real or feared harm is likely to occur to someone in a qualitative study. Harm, according to Miles and Huberman (1994), can take many forms. It can range from blows to their self-esteem (or looking bad) to being sued for malpractice or even to being arrested for harbouring information that breaks the law, for example after interviewing drug traffickers in an A and E unit. They advise that it is not easy to identify the levels of risk of potential harm and perhaps "even impossible" in qualitative research. This study will be designed to minimise such threats by being aware of ethical problems and resolving such dilemmas as they arise.

The initial stages involve the selection of the Delphi panel and of the staff who will take part in the survey. These participants will be briefed about the study and given a choice about taking part. The researcher will afterwards continue to be sensitive to any potential harm and risk to those participants or patients and their families, particularly when analysing data and communicating results.

Wax (1982) and Eisener (1991) argue that truly informed consent "is impossible" in qualitative studies because events during field study cannot be anticipated. Miles and Huberman (1994) maintain that weak consent usually leads to poor data because respondents will attempt to protect themselves in a mistrusted relationship. Informed consent in this study will, as far as possible, be based upon all participants being given extensive knowledge about the overall research objectives and aims of each phase of the methodology.

It was essential to obtain formal consent to the research from each of the participating Hospital Trusts. Letters seeking permission, for participant observation in their A and E units and for the involvement of their staff in the survey, were sought from the Directors of Medicine and Nursing and from the Senior A and E Consultants and Senior Nurse Managers in each Trust. It was assumed that most Trusts would need to seek permission from their own ethics committee. The letters seeking permission were accompanied by a précis of the original research proposal. They are presented in Appendices 1 and 2.

There was an intention also, when practical, to obtain verbal informed consent from all suitably aged children under observation; otherwise parent's permission was sought. A clear indication was given, to both children and parents about their right to refuse or withdraw. It was recognised that opting out was sometimes difficult in certain observational settings, for example in emergency situations, but nevertheless it was important wherever practical to reassure participants of their right to do so. Verbal permission was sought from all health care practitioners under observation; the nurses, doctors and other health care professionals.

Researchers often promise confidentiality and anonymity, "albeit superficially", according to Miles and Huberman (1994). Confidentiality was maintained wherever possible in this study

but a coding system for the names of staff in the staff survey was needed to facilitate reminders to non-respondents. Privacy, as discussed by Seiber (1992), can often include "control over others and prevention against giving protected information or receiving unwanted information". Miles and Huberman point out that it might be easy for a zealous researcher to either treat secrets casually or to seduce respondents into telling them. This study included the vigilant management of sensitive information. The design and conduct of the Delphi study and of the staff survey was such that it should reassure participants about the confidentiality of information between themselves and the researcher.

Registered nurses are bound by a confidentiality clause in their "Professional Code of Conduct". The researcher will adhere to that code. However, if unprofessional or unsafe behaviour is observed, as an accountable nurse practitioner she will need to intervene in any unsafe situations, even to the extent of negating valuable observational data. Ethical choices might present themselves if a malpractice is observed. The dilemma for the researcher under those circumstances was between intervention and the forfeit of future access. Although as a voluntary participant observer, her own professional accountability took precedence to ensure that unnecessary or harmful practices were not overlooked. In recent years there has been an increase in legal actions by members of the general public against professionals for alleged misconduct and this study did not intentionally support malpractices. As a qualified nurse, the researcher was very aware of her own abilities and her accountability for unsafe actions. Intervention was only attempted when the researcher felt competent to do so.

Serber (1992) pointed out that vulnerable persons, particularly those lacking authority, can be harmed in qualitative research. Children and their families were often in this category in a hospital situation. There was a tendency for some staff to feel vulnerable, in particular the

more junior grades of nurses. They may, for example, be concerned if they did not respond to a survey such as this. Also, when under observation, they might have had a need to behave in such a way that they considered was acceptable to the researcher. In this study, the researcher used her experience to recognise vulnerable participants and every attempt was made to develop and maintain a non-threatening environment for staff and clients during all of the observations.

It is possible, according to Guba and Lincoln (1981), for a qualitative study to be "faked" by an unethical researcher selecting data to support a desired outcome. That is an anathema to this research and the methodologies of this study which generated significant quantities of data which were fully presented, analysed and discussed in a manner which avoided findings or undisclosed conflicts of interest. The researcher was conscious of the many ethical challenges relating to this study and endeavoured to deal with them competently during the design, with the data being collected with attention to quality and then being reported with integrity.

In summary, ethical issues were considered very carefully during both the planning and execution of this study. The Flinders ethical framework for any qualitative research has been adapted to be specific to this study. Formal consent to this study in the first place was obtained from all stakeholders and consent was received from individuals participating in the study, both other health professionals and patients and their families where practical. The researcher was sensitive to all the ethical issues that arose during the study.

Chapter 5.

METHODOLOGY

5.1 Introduction

The challenge for this research programme was to choose methodologies that would facilitate the collection and collation of large quantities of qualitative data. This chapter describes the decisions that have been made. Experienced educationalists and clinicians within the nursing profession were known to be sources of rich qualitative data which might be accessed by a combination of listening to them or watching them within the workplaces or otherwise eliciting feedback from them, perhaps in a written format. A limited amount of quantitative information was also needed to be able to rank or weight the values of the qualitative data; for example by associating that qualitative data with the degree of experience of the respondents. After careful consideration it was decided to use separate research instruments to produce complimentary data capable of collation and discussion which should lead to answers to the research questions posed in section 1.1 above.

5.2 Phase 1: The Development of the Delphi Study

The first research instrument is a Delphi study. For the origin of the name Delphi, it is necessary to look to Greek mythology. The god Apollo Pythios, renowned for his ability to predict the future, was a master of Delphi. The technique that is known today as the Delphi method was initially developed and named as such in 1950 by the Rand Corporation of California as a mechanism to predict their business future. They needed long range planning, by methods which eliminated personal interactions as the controlling variables in decision-making; particularly the undue influence of strong-minded individuals or dominant personalities.

Strategic planners as well as researchers have applied the technique to many different fields since then; for example Dalkey and Harmer (1963) used the technique to predict the effects of massive atomic bombing. Nursing researchers have used the Delphi method: for example Bond and Bond (1982), Goodman (1986, 1987), Williams and Webb (1994) and Endacott et al. (1999). They all had a common underlying aim: to use the Delphi method to identify clinical research priorities specific to their areas of particular interest.

The Delphi technique is described as a method for enhancing creativity and promoting innovation and being primarily concerned with groups of experts (Robson, 1993). These attributes are both desirable and appropriate to this research, because of the need to access qualitative data from experienced people associated with the nursing of children. Hence its choice as one of the phases of the methodology of this research.

5.2.1 Aims and Technique

The aim of the Delphi technique is to generate discussion and facilitate judgements on a specific topic. In this research study the specific aim is to make judgements about the knowledge, skills and attitudes appropriate to nurses who care for children in A and E departments. In essence therefore, it will seek to produce judgements about ideals. It will not make judgements about the current level of those qualities, (these will be identified via phases 2 and 3 of this methodology). The Delphi technique is used as a procedure for structuring a communication process with either small or large groups of individual experts (Linstone and Turoff 1975). The distinguishing feature of the process is information gathered from the group of experts, with the opportunity for them as individuals to modify or refine their initial judgements based upon their reactions to the collective views of the group. Linstone and

Turoff maintain that the strength of the Delphi process is the ability to acquire rich sources of experimental data.

One of the advantages over committee involvement is the absence of face-to-face meetings of extremely persuasive or prestigious experts. Linstone and Turoff listed, as a negative characteristic of committee work, those committees that have domineering personalities with other members overshadowed by them. In a Delphi panel each member is intended to be on an equal footing and anonymous from each other. Since they do not meet, it maximises the probability of producing a greater frankness of opinion. Instead of meeting they receive a second questionnaire, which has a content and structure designed to explore further the issues and possibilities for consensus, which were raised by their individual answers to a first questionnaire. This process can be repeated until the researcher believes he or she has gained maximum benefit from the iteration.

It can consist of several rounds of questionnaires. This multiple iteration approach, according to Polit and Hungler (1991), is a means of effecting group consensus without the time-consuming approach of committee work. It allows a number of experts, without meeting as a group, to formulate and reformulate their opinions in the light of new information and changing group viewpoints. The process will be repeated at least twice for this study, when hopefully a consensus of opinion will have been obtained. This type of investigation was considered to be a relatively efficient and effective method for taking advantage of the combined expertise of a group of children's nurses who are not only specialists but are working in geographically spread A and E departments with different personal shift patterns; circumstances which would have made it extremely difficult to get them together in a meeting anyway.

Farrell and Scherer (1983) maintained that the Delphi approach is suitable for areas where there is a lack of empirical data, which, McKenna (1994) agrees, is pertinent to many areas of nursing. It is relevant to this research as the most likely method to obtain consensus as well as informed opinion, in an area where very little previously exists and which relates to the complexities of human activity. McKenna warns that modification without sufficient rigour of the data from the early rounds of questionnaire may threaten the validity of the original research. Hence the researcher needed to be to be vigilant, not only in her choice of experts but also with the analysis of the resulting data.

5.2.2 Selection of an Expert Panel

The use of experts can often lead to the pitfall of "illusory expertise" (Linstone and Turoff 1975), and Sackman (1975) emphasised the benefits of using non-experts also as part of the group. Goodman (1987) recommends the recruitment of individuals to a Delphi panel who have knowledge of a particular topic and are willing to engage in discussion, without necessarily being known as experts. Bond and Bond (1982) had previously commented that in nursing there exists no clearly identified expert, implying presumably that the pitfall of "illusory expertise" will not be a problem in the use of the Delphi technique for nursing research.

The researcher questions the view of Bond and Bond that there are no clearly identified experts in the nursing profession. There are degrees of expertise. It is not an absolute quality. Furthermore, one person may view another as an expert even if that person is too modest to assign that quality to him or herself. With these points in mind a group of known children's nurses working on a regular basis in A and E were contacted. It was decided that such a group, because of their experience, would include those with a higher degree of expertise and that the

range of expertise would avoid the problem of "illusionary expertise". They were to be well briefed about the aims of the research; McKenna recommending this personal approach to increase the return rate to the questionnaires they would receive.

An existing paediatric Accident and Emergency nursing group was approached in order to establish contact with specialists working in that field. The researcher attended one of their meetings and explained her remit and intentions for the study. The research aims were received with enthusiasm and they recommended a sample of nurses for the prospective Delphi panel. It included senior nurses from children's hospitals and from children's units attached to district general hospitals. It also included people that had been involved in relevant research. Twenty four potential participants were identified; experienced nurses working in either a Children's Hospital or in paediatric A and E Units within a large District General Hospital. Clinical researchers and authors of published research were also included.

5.2.3 Development of Questionnaire 1

One aim of this first round tool was to collect biographical data from the panel. Another aim was to give members the opportunity to develop and present information and opinions about required knowledge, skills and attitudes without being strongly directed.

The biographical data was needed to quantify as far as possible the range of degrees of expertise of the respondents; hence to consider the validity of their inclusion on the panel as knowledgeable specialists. This was the first part of the questionnaire. The remainder of this questionnaire was developed as an initial exploration of opinions about the knowledge, attitudes, skills and competencies that nurses require when caring for children following trauma in Accident and Emergency departments. These opinions, particularly when refined via

a second questionnaire, would be key inputs to answering the research questions of the study. This part of the questionnaire would be largely unstructured, giving the respondents considerable scope for free expression.

Although the group would not meet, it was considered important to minimise the likelihood that the questionnaires returned by any dominant individual would not be seen by others and therefore influence them. Hence, following the advice of Rauch (1979) who proposed the principles of "quasi anonymity"; the contact details of the respondents would be coded so that only the researcher would know the code directory. Their judgements and opinions were to remain strictly confidential between this researcher and each individual. Quasi-anonymity avoids the problem of associated with complete anonymity that, according to Sackman and Goodman (1987) leads to lack of accountability and encourages "hasty ill-considered judgements".

5.2.4 Pilot Study and Questionnaire 1

Issues of validity and reliability were addressed through careful and thorough piloting of the first round of the Delphi. There was a need to test, before use, that the questionnaire would effectively collect the quantitative data relating to panellist expertise and that it would not improperly direct the qualitative responses. Hence the questionnaire was viewed by a number of professional colleagues well known to the researcher and working with her within a Nurse Teacher sub-group of a professional association for child health. Their comments led to it being amended on a number of occasions until the researcher was satisfied that it did not contain any ambiguities for the panel. The final version of Questionnaire 1 is shown in Appendix 3.

5.2.5 Development of Questionnaire 2

The responses to the unstructured element of the first round of consultation were collated into themes or categories and sub-categories. The way this was done was to associate key words or clauses to the individual responses and in turn to associate those words and clauses to particular topics or sub-topics. To validate this analysis and limit research bias, a colleague who had undertaken research in a related field of study also categorised the data, and only slight differences in the groupings resulted.

The second questionnaire used the conceptual categories identified by the panel in the first round and gave the members of the panel the opportunity, for the first time, to indicate the importance of each item on a five-point scale. Scoring between one and five was considered helpful to quantifying priorities given by the panel overall as well as giving the individual panel members an ability to grade their opinions about each in turn. The opportunity was given to add any further comments and also any further items they considered to be important. It was recognised that, if the ratings or rankings produced a wide variability in response, or if a number of individuals had taken an extreme position relative to the median response, then a third round of consultation would be needed. (In practice a third round was not necessary). The second round instrument was developed and circulated to all 24 members of the panel. It is presented in Appendix 4.

5.3 Phase 2: The Development of a Survey of Staff Working in A and E.

5.3.1 Aims of the Survey

The aims of this second phase of research methodology were to identify the current knowledge, attitudes and skills of nurses who are already caring for children in a variety of A and E settings. (This contrasts with the Delphi study, which aimed to identify the ideals for these

qualities.) The sample population of recipients for the questionnaire was purposive with an anticipated 50% response from an estimated 100 to 150 qualified general nurses with different qualifications and experience and commitment to children. The sample aimed to include all of the nurses working with children in three hospital units of different types. The hospital units originally selected and designated A, B, and X in this study, were of the following types: -

Table 5.1: Types of Units originally selected for the Survey

Unit A.	A District General Hospital A and E Department employing Children's Nurses
Unit B	A Regional A and E Children's Unit in a General Hospital
Unit X	A District General Hospital A and E Department not employing Children's Nurses.

Unit A is a regional children's tertiary centre, but without a discreetly managed paediatric facility. Unit B is not set up specifically to be a paediatric unit; it is part of a generalised A and E department. Units A and B both employ some qualified children's nursing staff. Unit X was originally selected because it did not employ any qualified children's nurses although it treated a large number of children and adolescents. However, the management within this particular hospital declined the application from the researcher to include their nurses in the research sample.

There was no further Unit in the geographic area reasonably accessible to the researcher that had the same characteristics as Unit X, that is did not employ qualified children's nurses in their A and E departments. Another Unit was needed to increase the sampling frame. A fourth District General Hospital did give permission to involve their nurses. This Unit did employ qualified children's nurses but was distinct from Unit A because it had no discreet area for children. Hence it was involved in the survey and became Unit C for coding purposes.

Practical difficulties were anticipated in identifying in advance those staff who were and those who were not qualified children's nurses in each of the Units A, B and C. Hence the questionnaire was sent to all of the staff in all three Units.

5.3.2 Development of Questionnaire

The questionnaire was designed to obtain information about the current knowledge, attitudes and skills of nurses working with children in all three of the Units identified in Table 5.1 above.

Hague (1994) identifies questionnaire design as one of the basic building blocks of any survey research. A postal survey was considered to be the most appropriate method because of the large-scale response possibility and the relatively low cost of data collection compared with the logistics of face-to-face interviewing. There would be reduced risk of bias compared with face-to-face questioning, which could result in the researcher unintentionally directing the respondent in a particular direction. Furthermore, distribution by post would reach respondents throughout the targeted geographic area. The questionnaires included "tick box" and open-ended questions to facilitate both quantitative and qualitative data collection.

A major consideration was the possibility that there would be a low response rate, which in turn could lead to a bias in the responses if, for example, the distribution of respondents was skewed towards those particularly confident in their abilities as children's nurses. The intention to draw generalised conclusions from the subsequent analysis would then be negated. It was decided, if necessary, to send a second questionnaire about two weeks after the return date quoted for the first questionnaire. Another mechanism for increasing the response rate is the inclusion of a covering letter accompanied by an explanation of the research. Hague (1994)

recommends that a covering letter or introduction to the questionnaire can win or lose the respondent. Such an introductory letter was prepared and is presented in Appendix 5, along with the research aims as presented in Appendix 6. Hague and Oppenheim (1992) both recommend another tactic to get a better response; the use of a stamp-addressed white envelope; i.e. specifically not franked and not brown. This advice was also followed.

The appearance of this questionnaire was considered important by the researcher although Oppenheim (1992) suggests that no clear general conclusions can be drawn about the significance of that appearance. A conservative but pleasant appearance was considered to be important for busy nurses who need to be encouraged to consider its return a sufficiently positive experience. A guarantee of anonymity was considered desirable because of the sensitive relationships between staff and their managers and to encourage truth telling. However, this was considered unrealistic because of the need to follow up non-respondents. As an alternative, a conscious decision was made to include in the questionnaire design a mechanism for quasi-anonymity. The questionnaires were coded so that only the researcher knew the respondents contact details.

The structure of the questionnaire required much thought and attention. An easily understood format is of paramount importance otherwise as many as half of the respondents will decline to complete and return it (Polit and Hungler 1999). The questionnaire was designed, firstly to rank the respondents by measuring their status within the hospitals, the qualifications they already have or are working towards and their experience in working with children. These types of data can be quantified and are amenable if necessary to frequency distribution analysis. The major part of the survey was designed to determine the confidence or otherwise that nurses currently have about their own knowledge and competencies in the context of caring for

children and adolescents. This information was obtained by direct questions asking them to grade their confidence and competence and then by a series of relatively undirected questions which gave the opportunity to respond at length and in their own words. The completed questionnaire is presented as an Appendix 7.

5.4 The Development of Participant Observations.

Smith (1992) indicates that qualitative research and participant observation have become practically synonymous with nursing. Such research is broadly concerned with how the social world is interpreted, understood and experienced (Mason, 1996). It needs to be based upon methods that are flexible and sensitive to the social context and subject to methods of analyses and explanation. It is people centred, providing a rich description of human behaviour. It may be seen as less abstract or academic than other more scientific approaches but gives rich and meaningful data of present practical situations (Robson, 1993).

Children's nursing is certainly a people-orientated profession with care that tries to be holistic in approach as well as child, parent and family centred. Hence a study of it must focus upon the interactions between the people involved and between those people and the environment within which they find themselves. Observations in the field, that is in the working environment of A and E departments are a direct means of studying these interactions. The environment within which the nurses were working was also to be observed since, from the perspective of the children and their family and friends, the physical surroundings as well as the personal care contribute to their overall impression about the qualities of the treatment they receive.

5.4.1 Aims of the Observation Phase (3)

This third component of the research methodology was undertaken with the aim that the researcher would personally observe and hence assess the application of knowledge, attitudes and skills of nurses who are caring for children in a variety of A and E settings. It was hoped that the observations might lead to an understanding of the behaviours and experiences of the nurses as they actually occur in a real life-working environment. The findings are to be compared and contrasted with the outcomes of the survey (Phase 2) component of the methodology and add value by being a rich source of complex information. It was recognised that the knowledge of nurses could not be observed directly; only its application, which, combined with the skills acquired by education and experiences, resulted in their professional and observable degrees of competence.

5.4.2 Sampling Sites for Participant Observation

The planned stratified purposive sample of Units in which participant observation was to take place comprised of four different types of A and E units caring for children. Two of these units were those designated A and B when used for the Phase 2 survey (section 6.2) the other two units were: -

- Unit D: an A and E department in a children's hospital.
- A District General Hospital A and E department not employing children's nurses originally intended to be Unit X.

It was the intention of the researcher to start the observations in Unit D with the expectation that it might be used as a benchmark for the other Units. The aim was to observe the nurses working in all of the above Units but management rejected the application for access to Unit X which does not employ children's nurses. There was not another A and E unit without qualified children's nurses within a geographical area which made observation practical. Hence the observations were limited to Units A, B and D.

5.4.3 Methods of Data Collection

Polit and Hungler (1991) remind researchers that scientific observations should involve a systematic selection, observation and recording of behaviours and settings relevant to the problem under investigation. They discuss two extreme types of observational approach: unstructured and that which has a highly structured nature.

It is important to have a clear idea of what is to be observed. It might be a single incident or alternatively an occurrence which encompasses a variety of detailed dimensions. However, as Polit and Hungler point out, observing an infinite number of "detail" is absorbing. Hence the observer needs to have specific objectives to clarify the observational focus and to facilitate editing the collected data. The focus of attention and specific objectives in this study was the behaviour of nurses; that is their attitudes towards caring for children and adolescents (as distinct from adults), the application of their knowledge and hence their demonstrable skills and competence.

It was decided that both structured and unstructured observations would take place. The structured observational methods used would include the attitude and skills of the nurse caring for the child, not only in relation to the condition of the child, but also in relation to the

reactions of the child and parents to the care that they were receiving and to the environment within which that care took place. The skills were to include both verbal and non-verbal communication including tone of voice, facial expressions, touch and use of play. These were worth noting particularly because the literature search had revealed a lack of child–friendly environments and a lack of appreciation of the importance of family-centred care. Other structured approaches were intended to involve observation of any activities, which might include the assessment of children when entering A and E (triage) and the subsequent preparation and management of their treatments. A conscious decision was also made to examine the environment; whether or not it would be considered by the researcher to be conducive to the well being of the child and its response to trauma and his or her parents and siblings. Factors to look for would include a child friendly surrounding; appropriate pictures and toys and a minimum of austere, authoritarian images and unexplained high technology machines for example. The accompanying types and levels of noise are also relevant.

The observer should not disturb the scene being observed by her presence. However, potential real life issues of an ethical nature, related to intervention and concealment, were of concern to the researcher. The important decision was made, prior to the observations taking place that she would intervene if significantly unsafe practice was observed. An example would be recognition that errors in the application of drugs were about to be made. The researcher also felt some discomfort with the observer status being a passive role because its strict application meant no interaction with the children and families. As a qualified and experienced children's nurse, with a considerable ability to add value to the work of A and E units, this was difficult to accept. Hence the decision was taken to place herself in the position of an "acceptable incompetent". Hammersley and Atkinson (1983) defined this role as one which allowed the researcher to feel under no pressure to participate unless well within her capabilities. The

researcher also decided that she would limit herself to supernumerary role (as in fact she actually was) and hence resist pressures from her own caring disposition or from her temporary colleagues to participate fully in the work of the units.

Data analysis will have to take into account that the known presence of an observer might change the normal behaviour of the subject of that observation. Nurses and members of the medical staff will be aware of the researcher's presence and may possibly be aware of the underlying motives. If this transpires to be the case it will almost and inevitably bring about a change in normal activities, mannerisms and conversations. Subsequently, the researcher decided to operate for much of the time in participant observer role with unstructured observation but taking into account the need to observe the particular practices as described above. Participant observation also allowed the observer to collect verbal accounts from informants by asking questions about situations as they occurred. This type of questioning was opportunistic, taking advantage of appropriate circumstances as they arose.

Borg et al, (1983) advises that the validity of participant observation can be problematic because some of the difficulties which may be encountered can mask the situation being observed. It is subjective and hence it is difficult to check the reliability of the information gathered. Another difficulty is that the need to obtain freedom of access to the situation to be observed and the intensity of that observation when the opportunity has arisen can necessitate many hours of effort to obtain something like a coherent picture. Conversely, Robson (1993) suggests that what sounds like subjectivity to traditionalists can often be argued persuasively to have been objective. He recognises that the view of the traditionalist arises from a perspective that the social world involves subjective meanings and experiences but claims that the researcher/ observer is the research instrument and with great sensitivity and personal skills

can generate unbiased and worthwhile objective data. Problems that the researcher is likely to experience and which will be continually in her mind during the observation are the inevitable role conflict between uninvolved observer and practical nursing and also the need to avoid becoming emotionally involved.

The three separate research instruments that will be used in this study have been described. These are the Delphi technique which will collect the views of a panel of experienced children's nurses about the necessary attributes of competent children's nurses. Secondly, the survey of nurses of different backgrounds who are actually caring for children in A and E and who, by their responses to the survey, will identify their actual attributes. Finally a series of participant observations in A and E by the researcher, herself an experienced and qualified children's nurse, to observe the application in practice of the knowledge and skills of nurses and the influence or otherwise of the departmental environments and cultures within which they work. Synthesis of all of the subsequent results will facilitate analysis to achieve the overall aims of the study. The next chapter presents the results obtained from the application of the Delphi methodology.

Chapter 6.

KNOWLEDGE, SKILLS AND ATTITUDES IDENTIFIED BY THE DELPHI PANEL

The results from the Delphi study are information from a group of "experts" initially thinking independently then reviewing those judgements having received some feedback about the collective views of the group. The methodology, as described in section 5. 2, was a first round consultation via a questionnaire (Appendix 5) to the panel of "experts" and then a further round consultation via a modified second questionnaire (Appendix 6), which reflected the first round answers. Hence the results are presented in this chapter in a corresponding manner: the response in turn to the first and second questionnaires. This chapter will also discuss issues arising from these results in relation to the content for a children's nursing curriculum. However the main discussion, of the findings of the entire study, will be in the final Chapter.

6.1 First Round Consultation

6.1.1 Background of the Delphi panel

From a panel of 24 experts, all working with children in A and E, it was recognised that a response rate of 12 – 15 was required to meet the Polit and Hunger (1991) recommendation that a return of 50 – 60% is acceptable and valid. Thirteen responses were initially returned. Following letters of reminder a further three panel members returned the questionnaire, giving a final total of 16, a response rate of 66% of the intended panel. The preliminary part of the first questionnaire was used to identify the expertise of the panel by collecting biographical data about them. These data are presented in this section. The Job titles of the panellists are presented in Table 6.1.

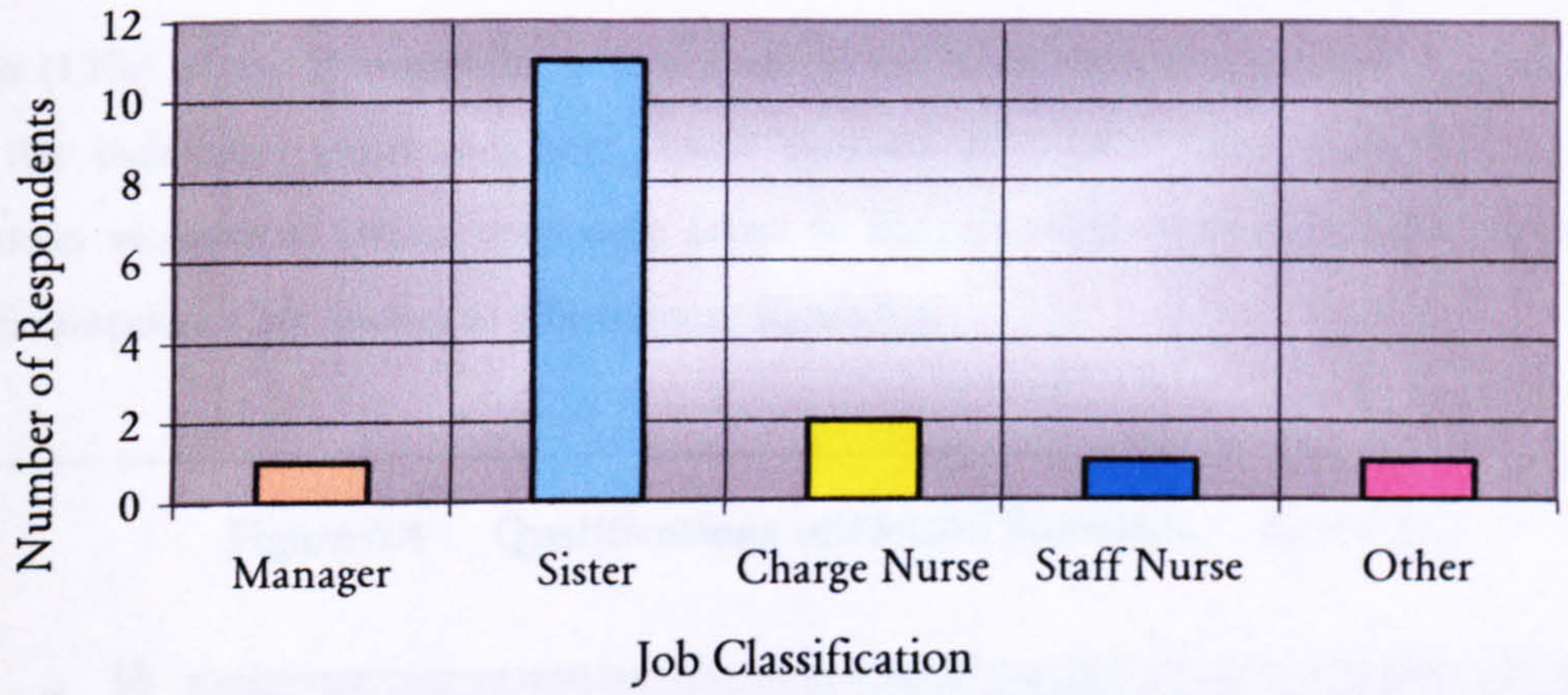
Table 6.1 Job Titles of Delphi Panel

Associate Director of Nursing and Nurse Adviser for Children's Services	1
Senior Nurse-Lecturer Practitioner: Lecturer and a Researcher in Paediatrics	2
Paediatric Emergency Nurse Practitioner: Emergency Nurse Practitioner Sister	2
Senior Charge Nurse: Senior Sister/A and E Sister: Sister Paediatric A and E	8
Staff Nurse	1
Others - Team Leader:Shift Leader	2

These titles suggest that at least 15 of the panellists are operating at a senior level in the care of children.

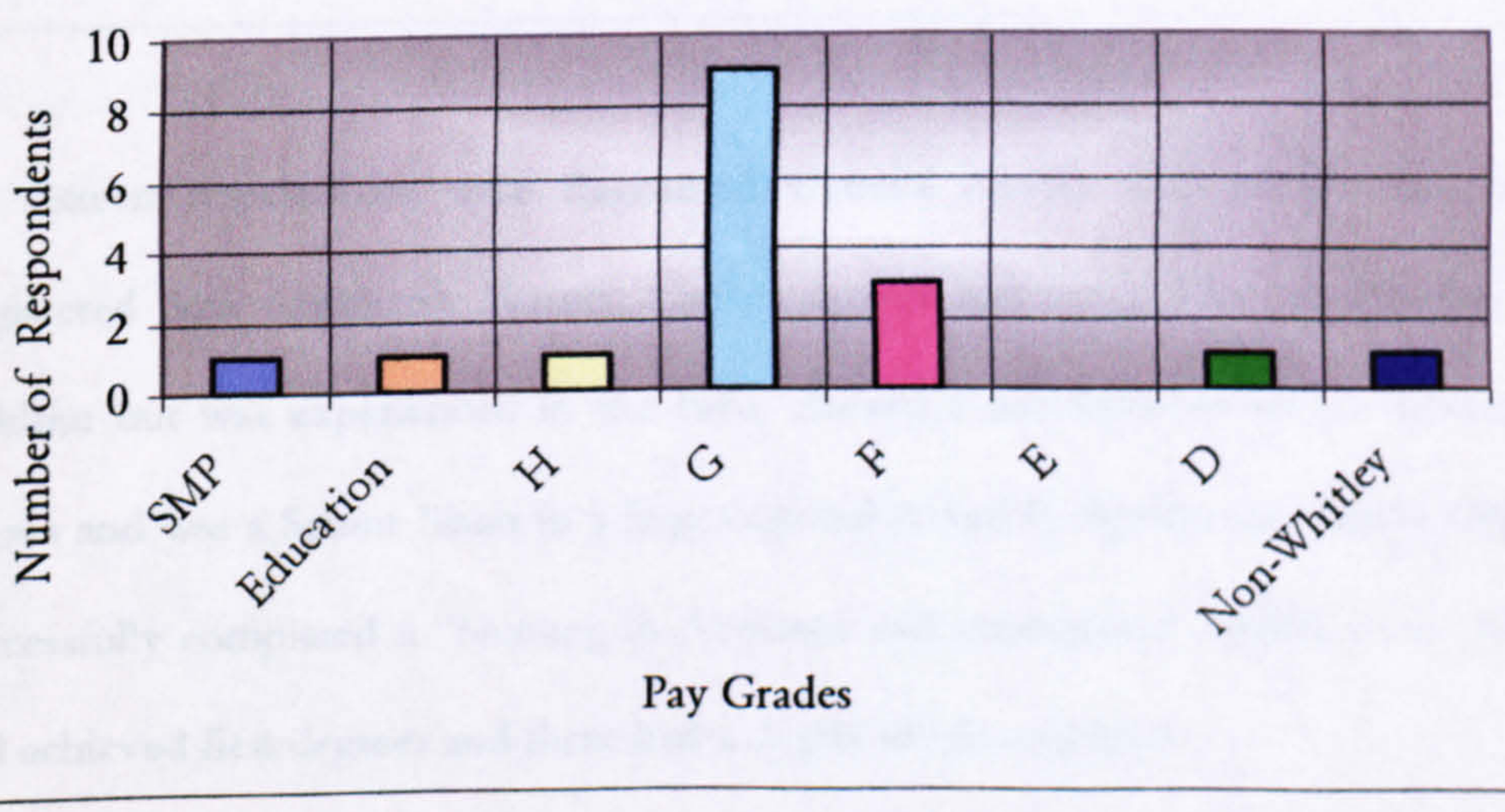
The answers to questions 2 to 11 were quantitative in nature and the results have been presented for clarity as histograms to describe the biographical detail of the panel. An indication of the seniority and functional responsibilities of the respondents is given by their job titles, but as a further check to justify their selection as "experts" they were asked to place themselves within one of five nursing categories. The histogram, figure 6.2, shows the dominance of sisters.

Figure 6.2: Classification of Jobs of Delphi Panellists.



Another measure of the experience of the respondents should be their salaries. They indicated their salary band within the well-known Whitley scale for nurses as presented in Figure 6.3.

Figure 6.3 Pay Grades of Delphi Panellists

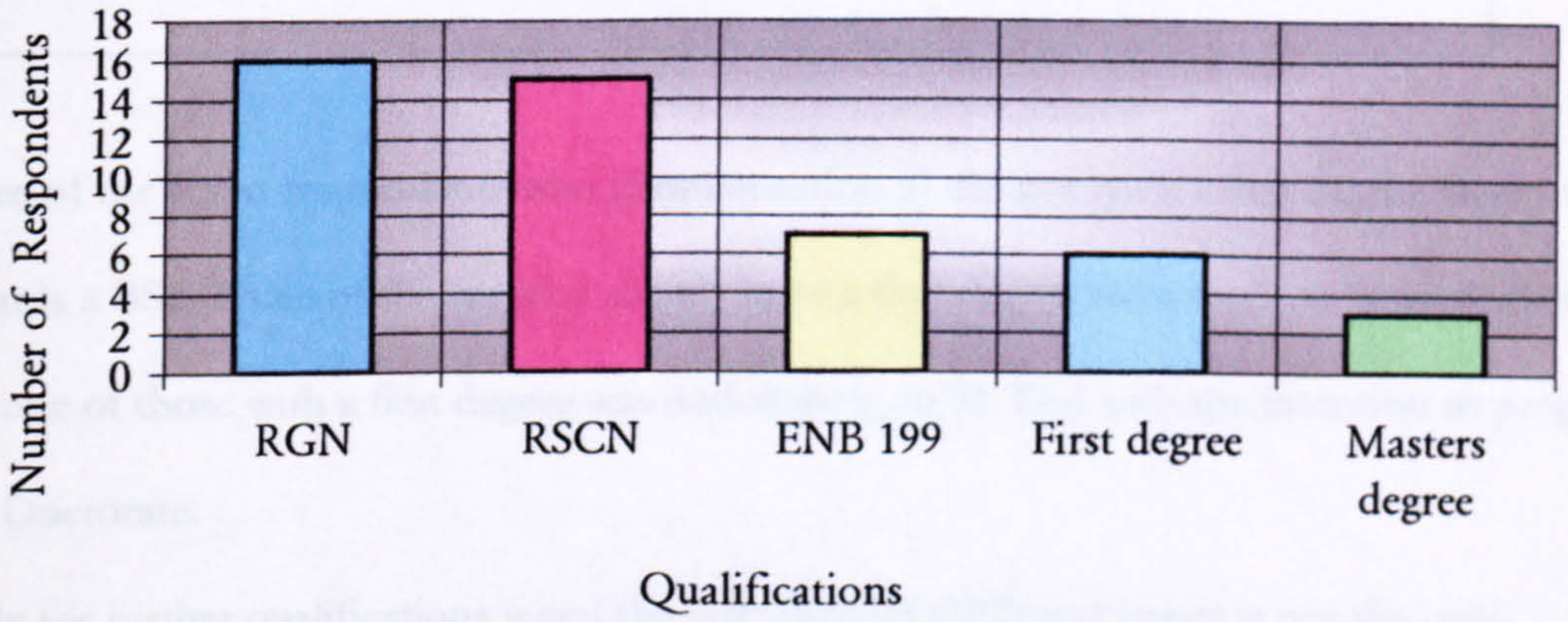


The labels H to D on the ordinate refers to the Whitley scale grading of nurses. SMP is the senior management pay scale and the Education grade is equivalent to that for university lecturers. These data reveal a preponderance (n=9) of G grade nurses, correlating with the job

titles and classifications revealed by the first two questions. Three of the respondents were not on the Whitley scale with two of them nevertheless indicating seniority based upon their pay.

Two (13%) of the 16 respondents were male. It was reasonable to expect that the qualifications of the individual panel members would provide additional information to support their election as experts. Hence they were asked to identify their (post registration) qualifications. Their responses are shown as a histogram: figure 6.4.

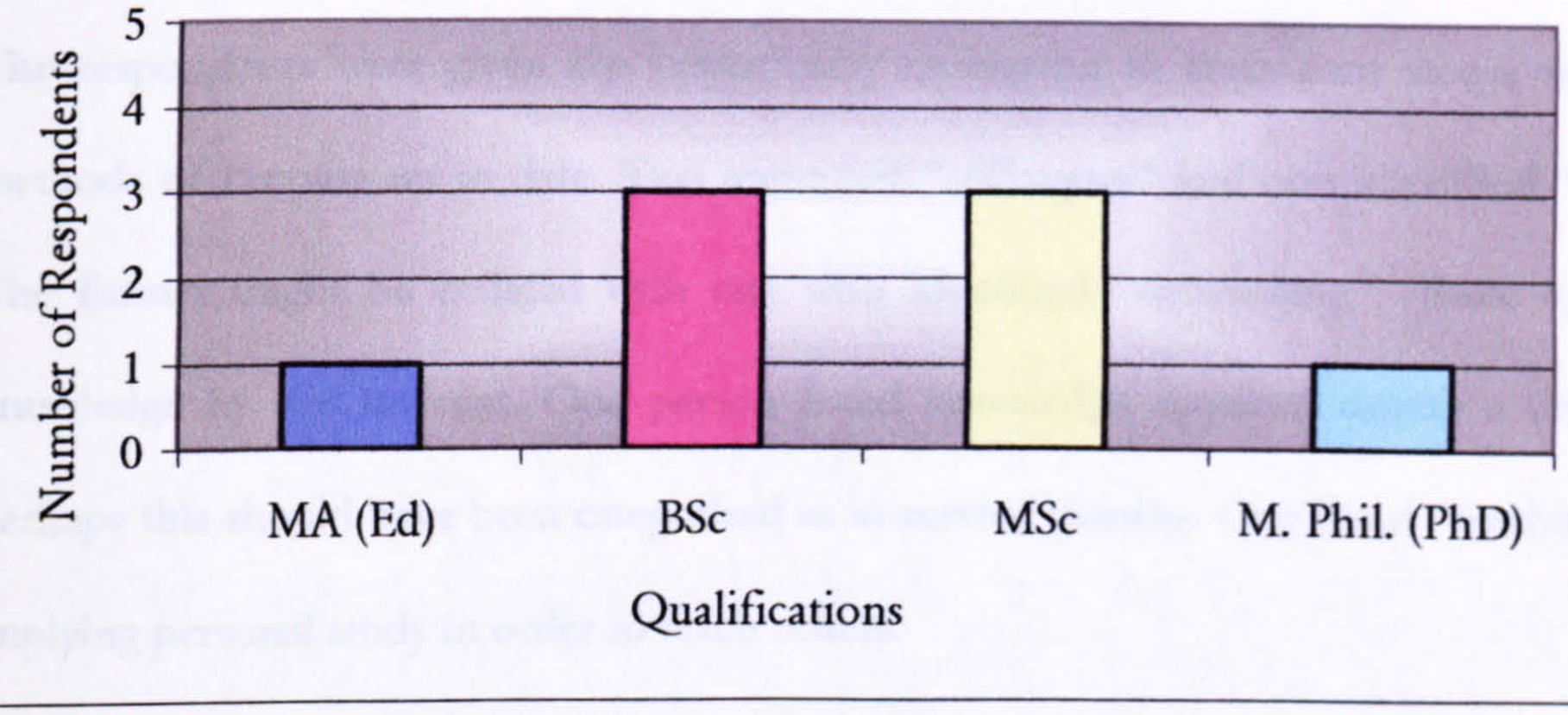
Figure 6.4 Qualifications of Delphi Panellists. (n = 16)



All sixteen respondents were Registered General Nurses with all but one of them also Registered Sick Children's Nurses. The exception did not hold a qualification to care for children but was experienced in the field, chaired a paediatric group of children's A and E nurses and was a Senior Sister in a large regional A and E department. Seven respondents had successfully completed a "Nursing in Accident and Emergency" qualification (ENB 199). Six had achieved first degrees and three had a degree at Masters level.

A positive attitude towards continuous professional development (CPD) is an indicator of the maintenance of expertise. Hence, the panel were asked to identify any commitment towards further awards. Their responses are categorised in the following histogram: Figure 6.5.

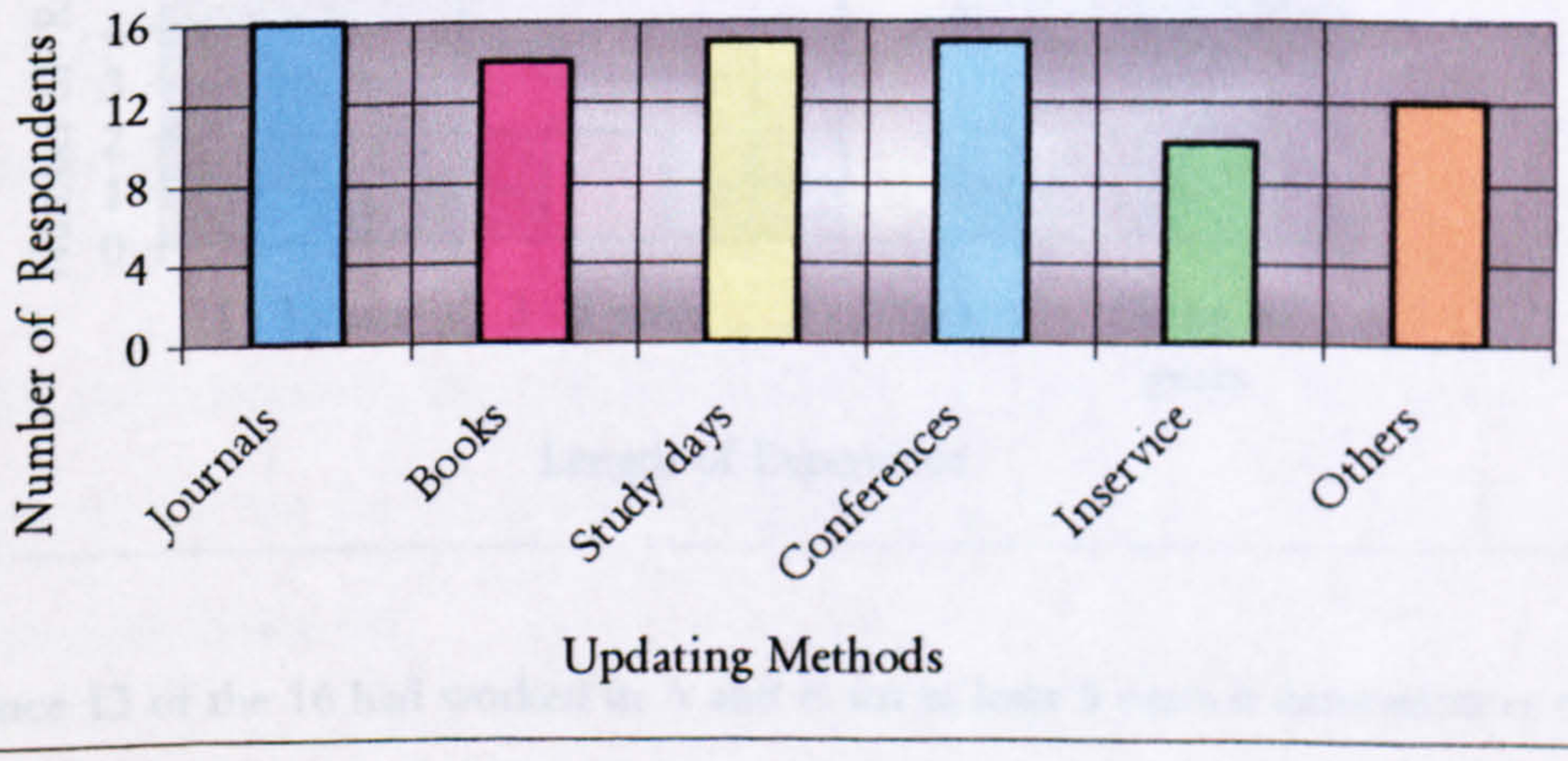
Figure 6.5 Qualifications in Progress. (N=16)



Three of the seven respondents who (from question 5) did not have a first degree were working towards a BSc. Three of the six who already have a first degree were working towards their MSc and one of those with a first degree was undertaking an M. Phil with the intention to progress to a Doctorate.

Study for further qualifications is not the only form of CPD and hence is not the only indicator of a determination to maintain expertise. Respondents were asked how they kept themselves up to date; the results are presented in Figure 6.6.

Figure: 6.6 Methods of Keeping upto Date

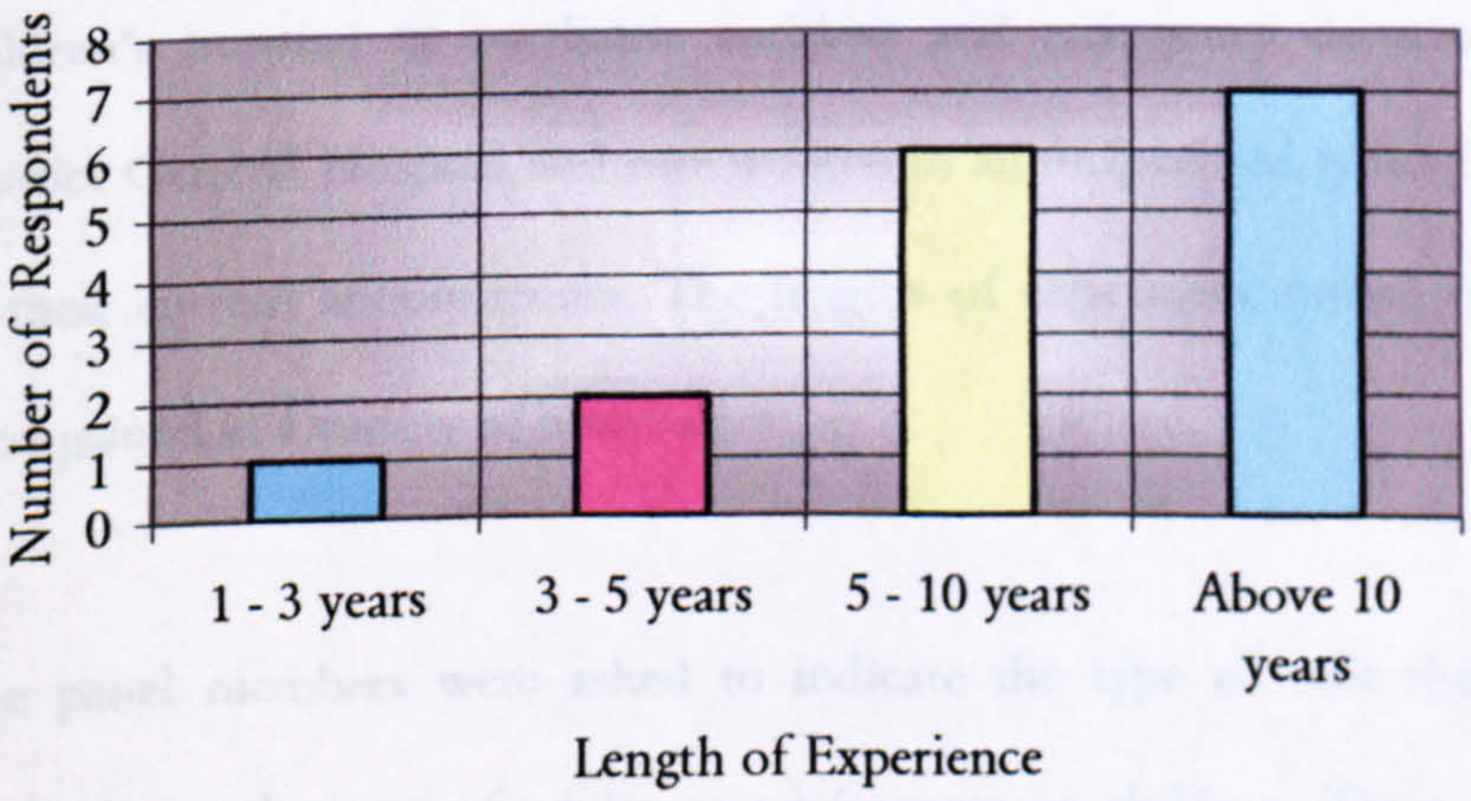


All sixteen read journals and fourteen of them also read books with all but one also attending study days and conferences. Just over half take advantage of in-service training.

The respondents were given the opportunity to expand in their own words upon "other" methods of keeping up to date. Two identified "colleagues" and one identified "newspaper". The former might be collated with one who identified "networking". Three updated their knowledge by the Internet. One person listed knowledge acquired during a degree course; perhaps this should have been categorised as in-service training. One listed "teaching", perhaps implying personal study in order to teach others.

It is reasonable to expect a relationship between expertise as measured by qualifications and the length of relevant experience. Hence information was sought about the length of time the panel members had worked in A and E departments. These data are presented in the following histogram: Figure 6.7.

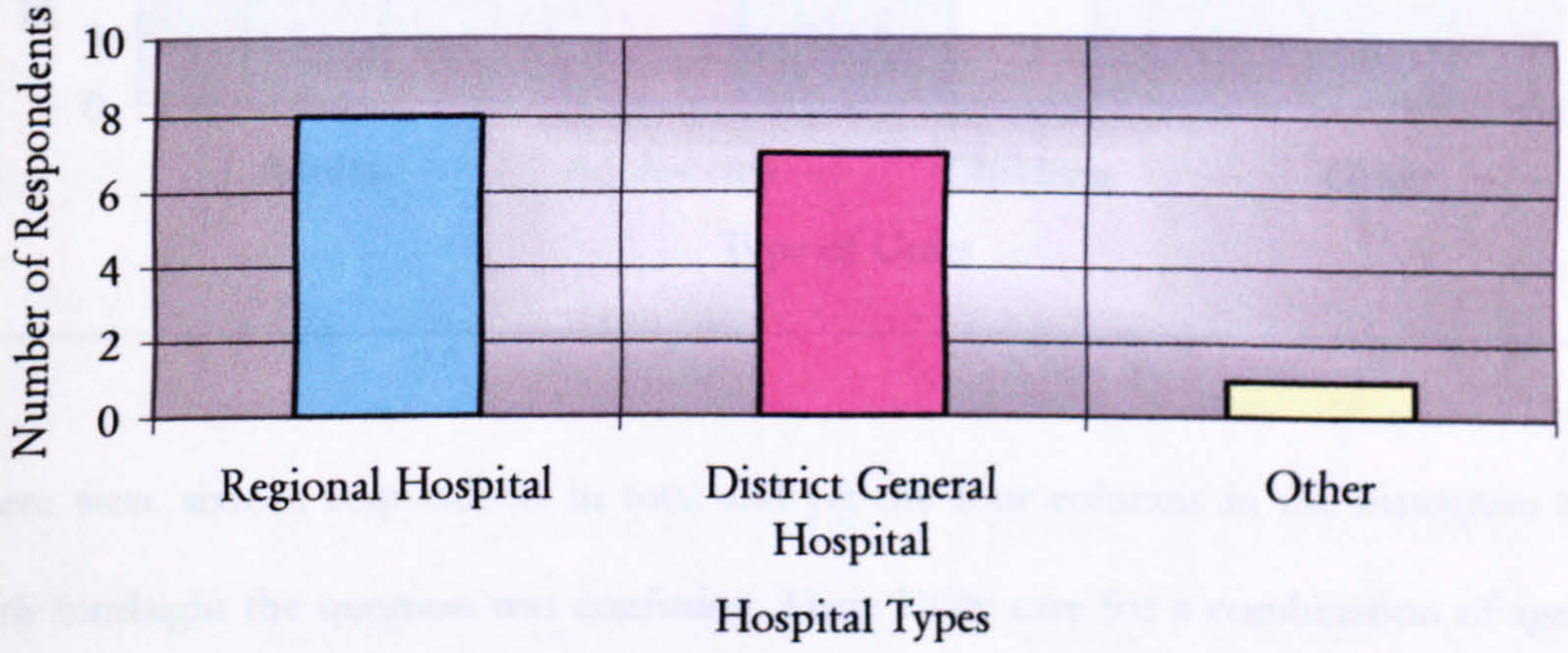
Figure: 6.7: Length of Experience Working in And E.



Since 13 of the 16 had worked in A and E for at least 5 years it demonstrates the considerable experience of the majority of the sample.

Having established the length of experience of the respondents it was appropriate to understand the environment within which they gained that experience. The sixteen respondents were asked to identify the type of hospital they worked in. The following histogram shows their responses and is presented in Figure 6.8.

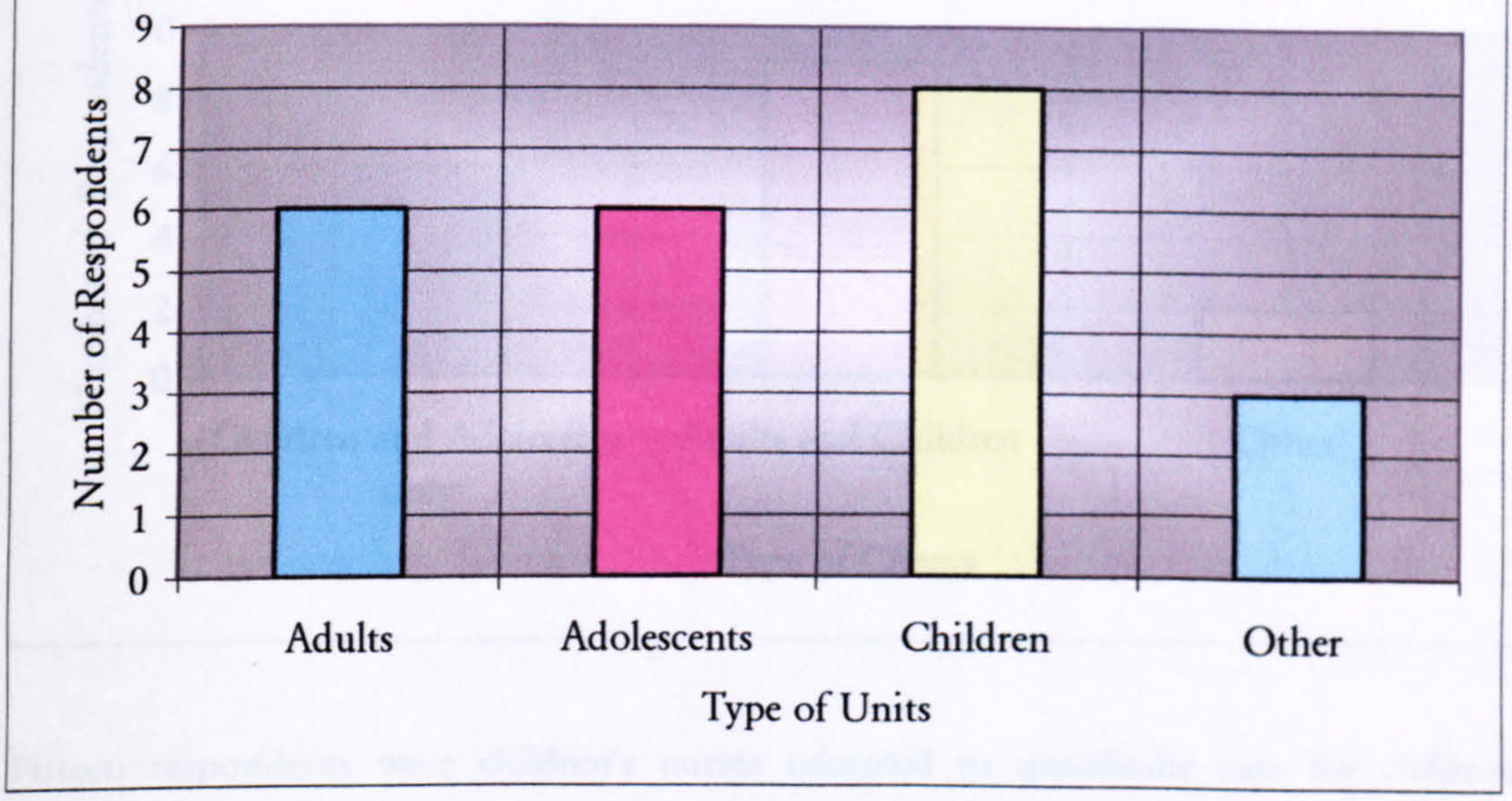
Figure 6.8: Types of Hospital



Eight respondents worked in a Regional Hospital with four of those eight working in a children's hospital or paediatric accident and emergency department. Seven worked in a District General Hospital and one worked in an unspecified type of hospital. These data refer to their current appointments. The lengths of experience presented in Figure 6.7 may have been gained in a variety of hospitals.

The panel members were asked to indicate the type of unit they worked within at their hospital; for the care of adults or adolescents or children. Their answers are shown in the histogram: Figure 6.9.

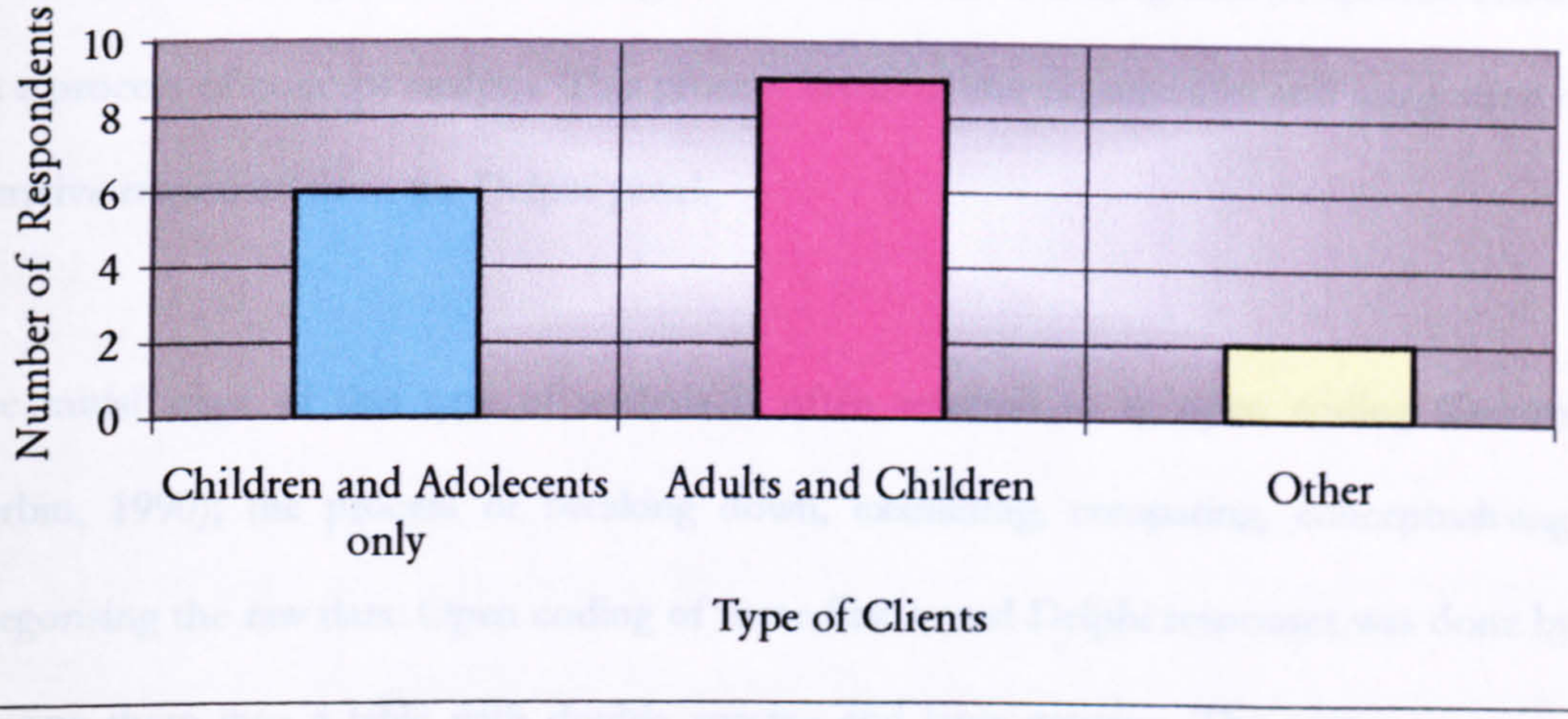
Figure 6.9: Types of Units that Panellists Work in. (n=16)



There were sixteen respondents in total and yet the four columns in the histogram total 23. With hindsight the question was confusing. Many Units care for a combination of age groups and hence the question should have been structured to reflect this. One respondent did express a lack of understanding of the question. Respondents did tick more than one option. These data are therefore of limited value.

The respondents were asked to indicate the type of clients they had; children only or children and adolescents only or if they worked with adults. They were given the opportunity to state, in their own words, if they categorised their clients in another way. The results are presented in Figure 6.10.

Figure 6.10: Types of Clients



Fifteen respondents were children's nurses educated to specifically care for children and adolescents. Even so, nine out of the sixteen respondents cared for adults in addition to children. Only six worked solely with children and adolescents, whilst none worked only with children. Two members indicated "other" and one of those did elaborate and offered their client group as adults, children and adolescents. The second response was from a lecturer who did not presently work with clients, although had experience in a discreet children's unit in a Regional Children's Hospital. This suggests the question could have been better formulated. They clearly (and understandably) concluded that the "Adult and Children" category excluded the adolescents they worked with. The conclusion must be that at least ten of the respondents care for adults as well as children. However, it might also underline the lack of clarity in the nursing profession between the definition of a child and when that child becomes an adolescent.

6.1.2 Underpinning Knowledge

The panel of expert nurses were asked to explain, in their own words, the underpinning knowledge they considered to be either essential or desirable when caring for children and

adolescents in an A and E department following trauma. Their responses have been collated into five broad categories of knowledge and in turn into sub-categories of specific knowledge via a process of concept analysis. This process involved the organisation and integration of the narrative responses from the Delphi panel.

The initial stage of this type of analysis is often referred to as open coding (Strauss and Corbin, 1990); the process of breaking down, examining, comparing, conceptualising and categorising the raw data. Open coding of these first round Delphi responses was done by first printing them into a table with double spacing and large margins. The responses were then considered item-by-item and associated with a concept or category of knowledge by making notes in the nearby margin. Notes were also made where appropriate, relating the responses to any known theory or any other research identified from the literature survey.

This open coding stage has been described as tedious and time consuming (Straus and Corbin 1990; Wheeler, 1996) but these authors warn that it is essential to tease out the underlying theory. After some time the researcher was able to synthesise the knowledge required from this study with her own background and experience as a nurse lecturer/ nurse practitioner and identify a pattern to the responses: being able to identify five categories of required knowledge. These were:

▪ Child Development
▪ Trauma
▪ Paediatric Concepts
▪ Communication
▪ Professional (Nursing).

Once that broad categorisation of required knowledge had been finalised the next stage was to identify the more specific sub-categories into which all of the raw data responses could be placed. The final structure for the responses is shown in the following table (6.11).

Table 6.11 Broad and Specific Areas of Knowledge Identified by the Delphi Panellists after the First Consultation

	No. of Panellists who consider areas	
	Essential	Desirable
Child Development		
Psychology	13	2
Physiology	8	1
Trauma		
Airway and Circulation	9	1
Management	4	2
Team	1	2
Triage	1	
Head Injuries	4	
Trauma	1	
Wounds	4	1
Fractures	1	
Pain	3	
Paediatric		
Pharmacology	13	
Equipment	1	
Family Care	8	5
Play	2	
Needs	1	
Neurological	1	1
Child Protection	9	1
Health Promotion	1	1
Fluid Balance	6	
Assessment	27	
Communication		
Paediatric /Child	21	
Team	1	
Family	1	2
Professional		
Attitudes	1	
Health Promotion	4	1
Ethics	5	
Resources	1	1
Other		1

One of the difficulties that the researcher found was the number of respondents who provided information relating more properly to skills and attitudes, presumably reflecting their interpretation of the word "knowledge". These responses were included as knowledge at this stage of the collation.

The areas of knowledge identified in Table 6.11 are headings only whilst Table 6.12 gives a more detailed list of the qualitative responses to the request for information about the underpinning knowledge that these experienced nurses considered either essential or desirable when caring for children in A and E after trauma. For example (the first row of the table), two nurses considered that cognitive development was essential underpinning knowledge in the context of the psychology of child development and (second row), seven nurses considered knowledge of the psychological stages of child development to be essential. In these examples the short phrases "cognitive development" and "psychological stages" have been chosen by the researcher to illustrate the raw data, which was in sentence format and by open coding placed in the psychology sub-category of child development. Because this researcher is an experienced nurse lecturer/ nurse practitioner she is confident that the knowledge implications of the raw data have been effectively summarised. Furthermore, the raw data are available for reference when the results are discussed in a subsequent chapter.

Table 6.12 A Detailed List of the Essential and Desirable Knowledge from Table 6.11.

Broad and Specific Areas of Knowledge		No of Panellists who consider the area:	
		Essential	Desirable
Child Development			
Psychology	Cognitive Development	2	
Psychology	Developmental stages	7	2
Psychology	Psychology of child's age	1	
Psychology	Psychological response of child	2	
Psychology	Behaviour	1	
Physiology	Physiological response of child	2	
Physiology	Physiological mechanisms of child	2	
Physiology	Paediatric fluid replacement		1
Physiology	Physiology and recognition of circulatory difficulties	1	
Physiology	Physiology and recognition of respiratory difficulties	1	
Physiology	Physiology of child	1	
Trauma			
Airway	Paediatric airway management	1	
Airway/Circ.	APLS (PAEDIATRIC BASIC LIFE SUPPORT)	2	1
Airway/Circ.	PALS	1	
Airway/Circ.	Advanced trauma life support	1	
Airway/Circ.	Maintenance of child's airway	1	
Airway/Circ.	Anatomical differences in child's airway	1	
Airway/Circ.	Differences of child and adult shock	1	
Airway/Circ.	Maintenance of child's circulation	1	
Management	Trauma care	1	
Management	TNCC/ATNC		1
Management	Trauma Process	1	
Management	Basic Trauma	1	
Management	Trauma management	1	
Management	Paediatric trauma research		1
Team	Paediatric trauma teams		1
Team	Trauma team management	1	
Team *Skills*	Anaesthetic skills –rapid sequence introduction		1
Head injuries	Glasgow coma score- understand	3	
Head injuries	Glasgow coma scale – interpret	1	
Trauma	Assessment of trauma	1	
Pain	Pain assessment tools	3	
Equipment	Maintenance of equipment for child's circulation	1	
Triage *Skills*	Triage skills	1	
Wounds	Wound healing	2	
Wounds	Wound care	1	
Wounds	Wound physiology	1	
Wounds	Fractures – Epi-physical Injury		1
Fractures	Fracture management	1	

Paediatric Concepts			
Pharmacology	Pharmacology, drug dosage	**2**	
Pharmacology	Drug calculation	**4**	
Pharmacology	Appropriate use and routes of administration	**3**	
Pharmacology	Pain Management	**4**	
Equipment	Use of equipment	**1**	
Family	Casey's model of Family Centred Care		**1**
Family	Family dynamics		**1**
Family	Cultural diversities		**1**
Family	Family- centred care	**6**	**1**
Family	Parental participation	**1**	
Family	Collaborative approach		**1**
Family Care	Family Unit awareness	**1**	
Play	Knowledge of play	**1**	
Play	Use of play	**1**	
Needs	Understanding of children's needs	**1**	
Neurological	Paediatric coma scale		**1**
Neurological	Assessment of neurological function	**1**	
Child protection	Child protection procedures	**4**	**1**
Child protection	Child protection indicators	**3**	
Child protection	Signs of neglect	**1**	
Child protection	Child abuse signs	**1**	
Health Promotion	Immunisation and vaccination schedules	**1**	**1**
Fluid balance	Fluid balance	**2**	
Fluid balance	Fluid replacement	**2**	
Fluid balance	Signs of dehydration	**1**	
Fluid balance	Signs of overload	**1**	
Assessment	Assessment of child with speed and accuracy	**1**	
Assessment	Recognition of acutely shocked child	1	
Assessment	Basic assessment of children	**1**	
Assessment	Normal ranges of all ages in BP	**5**	
Assessment	Temperature	**5**	
Assessment	Pulse	**5**	
Assessment	Respiration	**5**	
Assessment	Blood values	**1**	
Assessment	Good all round health assessment	**1**	
Communication			
Paediatric	Pain assessment	**9**	
Paediatric	Recognise and identify non-verbal expressions of pain	**1**	
Paediatric	Communication skills (verbal and non verbal) with:	**2**	
Family	Family	**1**	
Paediatric	Child (All ages)	**5**	
Team	Team	**1**	
Paediatric	Diversional therapy/ distraction	**2**	

Communication (Contd.)			
Paediatric	Use of non-invasive pain relief	**1**	
Paediatric	Use of non-invasive procedures	**1**	
Play	Theme tune of Thomas the Tank Engine	**1**	
Family Skills	Counselling skills		**1**
Family Skills	Teaching Skills		**1**
Professional			
Attitude	Calm confident manner	**1**	
Heath Promotion	Identify need for health promotion and accident prevention.	**2**	**1**
Heath Promotion	Accident prevention and referral	**1**	
Heath Promotion	Departmental safety issues	**1**	
Ethics	Ethical and moral issues	**1**	
Ethics	Awareness of issues of consent	**1**	
Ethics	Awareness of parental responsibility	**1**	
Ethics	Awareness of child abstention issues	**1**	
Ethics	Awareness of unaccompanied child issues	**1**	
Resources	Liaison with Primary Health Care Team	**1**	
Resources	Community resource		**1**
Other	RSCN/Child Branch Child		**1**

6.1.3 Essential and Desirable Attitudes.

The panel were then asked to list the attitudes they considered essential or desirable when caring for children after trauma. The same open coding approach was used as for the previous question and led to two broad categories of attitudes:

- **General Nursing Professionalism**
- **Child and Family Friendly**

Most of the raw data responses to this question were concise and distinct enough from their answers to be listed as presented. Editing was minimal and where it was done care was taken not to change the original meaning. All of the responses are presented in the following Table 6.3 listed within the two broad categories. The numbers of respondents who identified each specific attitude as "essential" or "desirable" is also recorded.

Table 6.13 Essential and Desirable Attitudes Identified by the Delphi Panellists after the First Consideration.

Broad Categories	Specific Attitudes	No. of Panellists who considered Attitude	
		Essential	Desirable
Professional	Friendly	8	
Professional	Non- judgmental	7	
Professional	Approachable	6	
Professional	Understanding	5	
Professional	Patient	4	
Professional	Caring	4	
Professional	Empathetic	4	1
Professional	Honest	4	
Professional	Calm	4	
Professional	Adaptable	3	
Professional	Happy (as appropriate)	3	
Professional	Professional	3	
Professional	Knowledgeable	2	
Professional	Flexible	2	
Professional	Competent	2	
Professional	Sympathetic	2	
Professional	Cheerfulness	2	
Professional	Open	1	
Professional	Pleasant	1	
Professional	Efficient	1	
Professional	Good communicator	1	1
Professional	Unhurried attitude	1	
Professional	Pleasant	1	
Professional	Sensible	1	
Professional	Good team worker	1	
Professional	Kind but firm		1
Professional	Consistent	1	
Professional	Accepting	1	
Professional	Reassuring	1	
Professional	Supporting	1	
Professional	Willing to share care	1	
Professional	Patience	1	
Professional	Sense of humour	1	
Professional	Open to change	1	
Professional	Decisive	1	
Professional	Good communication skills	1	
Professional	Systematic	1	
Professional	Level headed	1	
Professional	Willingness to influence health policies		1
Professional	Respective to all	1	
Professional	Listener	1	
Professional	Respects the knowledge/ skill of colleagues	1	
Professional	Promotes team work	1	
Professional	Confidentiality	1	
Professional	Willingness to listen	1	

Professional	Tolerant	1	
Professional	Skilful	1	
Professional	Kind	1	
Professional	Compassionate	1	
Professional	Attentive	1	
Professional	Sharing of updated knowledge with colleagues	1	
Professional	Outgoing	1	
Professional	Trustworthy	1	
Professional	Organised	1	
Professional	Welcoming	1	
Professional	Non-prejudicial	1	
Child Friendly	Confident to child and family	6	
Child Friendly	Child friendly	2	
Child Friendly	Aware of family needs	2	
Child Friendly	Communicative to level of child	2	
Child Friendly	Empowerment of parents and decision making	2	
Child Friendly	Barriers of professionalism broken down when communicating with children	1	
Child Friendly	Act as parental advocate	1	
Child Friendly	Tune in to Child's current emotional state	1	
Child Friendly	Non-threatening dress	1	
Child Friendly	Approachable to child	1	
Child Friendly	Informative to parents	1	
Child Friendly	Allay parental anxieties	1	
Child Friendly	Demonstrates a liking for children	1	
Child Friendly	Sensitive to children's needs	1	
Child Friendly	Belief in rights of child and family		1
Child Friendly	Enjoy paediatric nursing	1	
Child Friendly	Respects the needs of children, young people	1	
Child Friendly	Appropriate to child and family	1	
Child Friendly	Good converser with children of all ages	1	
Child Friendly	Responsive to child and family anxiety	1	

These data, from these experienced children's nurses, included 56 items relating to general nursing professional attitudes with only 20 relating to the attitudes required to care specifically for children and their families. Most were labelled as "essential" attitudes. Very few were labelled at the level of "desirable" only. This suggests a very clear view of key necessary attributes.

6.1.4 Essential and Desirable Skills

The final question in the first round of consultation was to ask the Delphi respondents for a list of the skills they thought were essential and desirable for nurses caring for children in an A

and E unit. Concept analysis with the process of initial open coding of their responses was again carried out as described for question 12 and led to the following six broad categories of responses.

▪ **Children**
▪ **Communication**
▪ **Paediatric**
▪ **Trauma**
▪ **Assessment**

There are similarities between these categories and those developed by open coding of the lists of appropriate attitudes and knowledge. This was considered encouraging, creating probable building blocks for discussion of the total research findings. The raw data responses were again collated with minimal editing into categories of specific skills taking advantage of this researcher's own knowledge and experience. All of the responses are presented in the following Table 6.14, together with the numbers of panellists who identified each specific skill as either essential or desirable.

Table 6.14 Essential and Desirable Skills Identified by the Delphi Panellists after the First Round Consultation.

Specific Skills		No of Panellists who considered Skill	
Children		**Essential**	**Desirable**
Weigh accurately		4	
Utilisation of play and distraction		3	
Teaching child and family		3	
Accurately monitor a child's temperature		3	
Administration of fluid replacement		2	
Distraction therapy		2	
Measure height accurately		1	
Accurate use of scales		1	
Interpret vital signs		1	
Acceptable discomfort for a child		1	
Paediatric dosage calculation		1	
Basic child care		1	
Changing a nappy		1	
Accurate use of Breslow tape		1	
Communications			
Good verbal skills		8	
Health promotion accurate and appropriate		3	1
Counselling		2	
Team member		1	
Reassurance to child and family		1	
Reading stories		1	
Gaining co-operation with child and family		1	
Good non-verbal skills		1	
Referral to appropriate services			1
Paediatric			
Manage children's equipment e.g. syringe driver		5	
Management of head injuries		4	
Pain management record and control		4	
Oxygen saturation and interpretation		2	
Urine specimen collection		2	
Drug calculations		3	
Basic Life support		2	1
IV drug administration		2	1
Administration of medicines		2	
Cannulation		1	2
Phlebotomy / venepuncture		1	1
Nursing process to child and family:	Assess	2	
	Plan	1	
	Implement	1	
	Evaluate	1	
Ability to :	Predict	1	
	Interpret	1	
	Present	1	

Paediatric (contd.)		
Injury mechanisms	**1**	
Glucose monitoring	**1**	
Maintain airway by use of nasal mask	**1**	
Administration of nebulisers	**1**	
Observation to determine alteration in condition	**1**	
Recognition of seriously ill child	**1**	
Recognition of change in a child's condition	**1**	
Positioning	**1**	
Correct handling of patient e.g. log roll	**1**	
IV Pumps	**1**	
Recognition of cardiac rhythms	**1**	
ECG	**1**	
Use of Glasgow scale	**1**	
Trauma		
Splinting	**8**	**1**
Plastering	**8**	**1**
Steristripping	**4**	
CPR	**3**	
Gluing	**3**	
Suturing	**2**	
Wound care management	**1**	
Wound closure	**1**	
With wriggly child	**1**	
Wound management	**1**	
Dressings	**1**	
Bandaging	**1**	
Defibrillation	**1**	
APLS (Paediatric Basic Life Support)	**1**	**2**
Advanced life support	**1**	**1**
Application of a Thomas Splint	**1**	
Intra-osseous infusion	**1**	
Trauma management	**1**	
Immobilisation of cervical spine	**1**	
Cervical/ spinal immobilisation technique	**1**	
Management of fractures	**1**	
Management of immobilisation and use of collar	**1**	
Important use of percutaneous anaesthesia	**1**	
Insertion of oro-pharyngeal airway	**1**	
Control of haemorrhage	**1**	
Paediatric ENP course skills		**2**
Specialist Nurse practitioner degree		**1**
TNCC/ ATNC		**1**
Intubation		**1**
Assessment		
Monitor vital signs	8	
Assessment of head injury and record	6	
Rapid and accurate assessment of child	4	
Triage and assessment	2	
Testing of urine	2	

Assessment (Contd.)		
History taking	1	
Effective documentation	1	
Assessment of physical condition	1	
Assessment of psychological condition	1	
Adaptable	1	

6.2: Validation of Categorisation of First Round Responses.

A colleague, who had previously undertaken research into a related area of nursing practice, subjected all of the raw data that are the responses to questions in sections 6.1.2 to 6.1.4 to an independent open-coding data analysis. She was unaware of the researcher's categories and subcategories. There was considerable agreement between her identification of the categories and sub-categories and those of the researcher. The differences were literary in nature rather than representing different concepts but did stimulate this researcher to reconsider her own category descriptions and finally to re-present them more concisely and explicitly. The results are shown in Table 6.15.

Table 6.15 Final Categories and Subcategories of Delphi Panel First Round Identification of necessary Knowledge, Skills and Attitudes.

Knowledge	
Paediatric Basic Concepts.	Psycho-social, sociological
	Physiology
Generic Paediatric Nursing Knowledge	
Accident Emergency Paediatric Nursing	General
	Trauma and resuscitation
Professional Nursing Knowledge	
Attitudes	
Professional	
Child And Family Friendly.	
Skills And Competencies	
General Paediatric Nursing Skills	
Accident And Emergency Paediatric Skills	Assessment
	Management.

Categorisation of these subjective answers was expected to help stimulate the second round consultation.

6.3: Delphi Process Second Round Consultation

The questionnaire for the second round Delphi consultation was redrafted using the validated categories given in 6.2 above. The questionnaire itself is presented in Appendix 7. It was sent to all 24 members of the original panel of experts. On this occasion the respondents were asked to grade the importance of the knowledge, skill and attitude they identified using a "Likert Scale" from 5 to 1; five being the most important to one being the least important. This was considered necessary because the first round questionnaire had given most of the identified attributes the single ranking of "essential".

There was an increased response rate of 17 (70%), consisting of 15 of the 16 respondents to the first round plus 2 who did not respond at that time. A 70% response rate is good for a questionnaire survey (Polit and Hunger 1999).

The final results of the Delphi exercise, that is the result of the second round consultation, which itself was a refinement of the first round consultation, is given in the following Table 6.16. The topics in the Table are those of the validated categories and the sub-categories. The specific topics are listed. The number associated with each specific topic is the number of panellists who gave that topic the Likert scale score indicated by the column heading.

There are several ways in which some overall measurement of priority for each topic might be calculated, for example the number of respondents who scored that topic 4 or higher might be counted. It was decided that a weighted score was the best overall indication of priority. Hence

the "Priority Total" in the final column is the sum of the products of the Likert scale grade and the number of respondents for each topic. For example, the priority total for "Physiological differences of a child" is 13 x 5 plus 4 x 4 equalling 81. Hence the desirable knowledge, attitudes and skills as determined by the Delphi panellists after their two rounds of consultation, are shown in Table 6.16 in descending order of priority, within the main topic areas.

Table 6.16: Knowledge, Attitude and Skill Priorities for Nurses caring for Children in A and E

Topic		Likert Score and No. of Panellists in each Priority					Priority Total
		5	4	3	2	1	
KNOWLEDGE							
Paediatric Basic Concepts							
Physiological differences of the child		13	4				81
Anatomical differences of the child		12	4	1			79
Physiological responses of the child		11	6				79
Children's Needs		11	4	2			77
Communication skills non-verbal		10	5	2			76
Psychological response of child		9	6	2			75
Cognitive development		7	8	2			73
Communication skills verbal		8	6	2	1		72
Behavioural norms		6	7	3	1		69
Knowledge of play		7	4	5			66
General Paediatric Knowledge							
Pain assessment		16	1				84
Appropriate use and routes of administration		13	4				81
Drug dosage		13	3	1			80
Consent issues		12	4	1			79
Vital signs – normal ranges:	Pulse	12	4	1			79
	Temperature	12	3	2			78
	Respirations	12	3	2			78
Family-centred/negotiated care		10	6	1			77
Child abuse		13	2	1			76
Use of equipment		10	5	2			76
Child protection procedures		12	3	1			75
Neurological function		9	6	2			73
Vital signs: Blood pressure		11	3	2			73
Good all round health assessment		6	9	1	1		71
Pharmacology		6	7	3	1		69
Fluid balance (1 void)		7	6	3			68
Immunisation and vaccination schedules		3	8	4	2		63

Topic	Likert Score and No. of Panellists in each Priority					Total Priority
	5	4	3	2	1	
Accident and Emergency Paediatric Knowledge						
General						
Triage skills	15	2				83
Glasgow coma scale:	12	3	2			78
Understand	9	6	1			72
Interpret	8	8				72
Fracture management	6	9	2			72
Trauma and Resuscitation						
Maintenance of child's circulation	17					85
Paediatric airway management	17					85
APLS (Paediatric Basic Life Support)	13	3	1			80
PALS	11	5	1			78
Trauma team management	9	5	2	1		73
Professional Nursing Knowledge						
Calm confident manner	14	3				82
Ethical and moral issues	6	10	1			73
Departmental safety issues (1 void)	10	4	2			72
Accident prevention and referral	7	7	3			72
Identify need for health promotion and accident prevention	5	9	3			70
Liaison with primary health care team	4	9	3	1		67
Community resource	1	9	5	2		60
ATTITUDES						
Professional						
Good communicator	15	2				83
Competent	16		1			83
Good communication skills	14	3				82
Caring	15	1	1			82
Non-judgemental	14	3				82
Honest	14	2	1			81
Approachable	14	2	1			81
Patient	12	5				80
Calm	13	3	1			80
Professional	13	3	1			80
Reassuring	13	3	1			80
Supporting	13	3	1			80
Non-prejudicial	12	4	1			79
Adaptable	12	4	1			79
Patience	10	7				78
Trustworthy	11	5	1			78
Listener	11	4	2			77
Understanding	11	4	2			77
Efficient	12	3	1	1		77
Skilful	11	4	2			77
Level headed	11	4	2			77
Compassionate	11	4	1	1		76

ATTITUDES Professional (Contd.)						
Attentive	**12**	**2**	**2**	**1**		**76**
Empathetic	**10**	**5**	**2**			**76**
Pleasant	**9**	**7**	**1**			**76**
Organised	**8**	**6**	**2**			**75**
Welcoming	**10**	**5**	**1**	**1**		**75**
Sharing of updated knowledge with colleagues	**10**	**4**	**3**			**75**
Tolerant	**10**	**4**	**3**			**75**
Willing to share care	**10**	**5**	**1**	**1**		**75**
Knowledgeable	**9**	**6**	**2**			**75**
Kind	**11**	**3**	**2**		**1**	**74**
Decisive	**9**	**6**	**1**	**1**		**74**
Systematic	**8**	**7**	**2**			**74**
Consistent	**9**	**5**	**3**			**74**
Good team worker	**7**	**9**	**1**			**74**
Sensible	**8**	**7**	**2**			**74**
Friendly (1 void)	**12**	**1**	**3**			**73**
Sympathetic	**8**	**7**	**2**			**74**
Sense of humour	**7**	**8**	**1**	**1**		**72**
Open	**8**	**5**	**4**			**72**
Happy (as appropriate)	**7**	**7**	**1**	**2**		**70**
Kind but firm	**7**	**6**	**3**	**1**		**70**
Open to change (1 void)	**8**	**5**	**3**			**69**
Willingness to influence health policies	**6**	**6**	**4**		**1**	**67**
Cheerfulness	**6**	**7**	**2**		**1**	**65**
Accepting	**5**	**7**	**3**	**1**	**1**	**65**
Outgoing (1 void)	**4**	**4**	**5**	**2**	**1**	**56**
Child and Family Friendly						
Approachable to child	**16**	**1**				**84**
Confidentiality	**15**	**1**				**82**
Respects the needs of children and young people	**14**	**2**	**1**			**81**
Responsive to child and family anxiety	**14**	**2**	**1**			**81**
Child friendly	**13**	**4**				**81**
Belief in rights of child and family	**14**	**2**	**1**			**81**
Confident to child and family	**14**	**1**	**2**			**80**
Communicative to level of child	**12**	**5**				**80**
Sensitive to children's needs	**12**	**5**				**80**
Willingness to listen	**13**	**2**	**2**			**79**
Informative to parents	**12**	**3**	**2**			**78**
Allay parental anxieties	**12**	**3**	**2**			**78**
Tune into child's current emotional state	**11**	**5**	**1**			**78**
Appropriate to child and family	**13**	**1**	**3**			**78**
Respective to all	**12**	**3**	**2**			**78**
Demonstrates a liking for children	**12**	**4**		**1**		**78**
Empowerment of parents and decision making	**11**	**4**	**2**			**77**
Enjoy paediatric nursing	**11**	**4**	**2**			**77**
Good converse with children of all ages	**9**	**7**	**1**			**76**
Aware of family needs	**10**	**5**	**2**			**76**
Barriers of professionalism broken down when communicating with children	**10**	**5**	**2**			**76**
Act as parental advocate	**10**	**5**	**2**			**76**
Respects the knowledge/ skill of colleagues	**9**	**5**	**2**	**1**		**73**

ATTITUDES Child and Family Friendly (Contd.)						
Promotes team work	7	7	2	1		71
Non-threatening dress	7	3	5	2		66
Unhurried attitude	4	7	3	2	1	62
SKILLS AND COMPETENCIES						
General Paediatric Nursing Skills						
Verbal communication	16	1				84
Pain management	16	1				84
Non-verbal communication	15	2				83
Calculation of drugs	14	3				82
Administration of medicines	14	3				82
Administration of fluid replacement	14	3				82
Reassurance to child and family	12	5				80
Administration of nebulisers	11	6				79
Management of children's medical equipment	11	5	1			78
Use of Glasgow coma scale	11	4	2			77
Taking and recording vital signs (1 void)	14	1	1			77
Distraction and play therapies	8	8	1			75
Teaching child and family	9	5	3			74
Accurate measurement of height and weight (1 void)	11	3	2			73
Play	7	8	2			73
Health promotion	5	10	2			71
Collection of specimens	8	2	6	1		68
Counselling	6	7	2	1	1	67
Nappy changing	2	6	3	2	4	51
Specialist practitioner degree (1 void)	1	4	5	1	5	43
Accident and Emergency Skills						
Assessment						
Rapid and accurate assessment of child	17					85
Ability to interpret	13	2	1	1		78
Ability to predict	11	4	1	1		76
Ability to present	11	3	2	1		75
Observations of changes (3 voids)	11	3				67
Accurate use of Breslow tape	7	5	3		2	66
E.C.G. assessment	3	6	4	2	2	57
Management						
Wound closure - Gluing	11	5	1			78
Wound closure - Steristripping	11	5	1			78
Immobilisation and splinting	11	5	1			78
Management of fractures	10	6	1			77
Wound care	10	6	1			77
Dressings and bandaging	9	7	1			76
Application of Plasters	8	6	3			73
Administration of Entonox	8	5	4			72
Wound closure – Suturing (1 void)	7	6	1	2		66
Application of a Thomas splint	7	4	3	2	1	65
IV drug administration	5	4	7	1		64
TNCC/ ATNC	4	7	4	1	1	63
Intra-osseous infusion (1 void)	2	7	4	3		56
Cannulation	2	4	4	3	4	48

SKILLS AND COMPETENCIES : Management (Contd.)						
Paediatric ENP skills	**2**	**4**	**4**	**3**	**4**	**48**
Phlebotomy	**2**	**4**	**4**	**3**	**4**	**48**
Intubation	**1**	**2**	**5**	**3**	**6**	**40**

6.4 Issues arising from the Results of the Delphi Study

The methodology for the Delphi study described in chapter 5.2 was followed for two rounds of iterative information gathering. At that time a third round was considered unnecessary; the quantity and quality of raw data received was considered sufficient for the purposes of this study. The decision was made to not unequivocally demonstrate consensus by further rounds of consultations. For this reason therefore, strictly speaking these results represents the output of a partial Delphi study.

The Delphi panel of experienced children's nurses prioritised the knowledge, skills and attitudes used by nurses for the optimum care of children in A and E after trauma. The complete list of those nursing attributes and the priorities given to them by the panel are given in Table 6.16. To facilitate discussion, part of that table is re-presented below as Table 6.17, but only for those attributes that had a total score of at least 80 from the panel. At this point it is appropriate to emphasise that the score of 80 is not a clear cut–off point between the higher and lower priority attributes, but this point was chosen in order to focus the discussion. However, it is important in light of the literature to discuss some of the important factors that scored less than 80.

Table 6.17 The Knowledge, Skills and Attitudes that were given Highest Priority by the Delphi Panel.

Knowledge:	
Paediatric airway management	**85**
Maintenance of child's circulation	**85**
Paediatric Airway Management	**80**
Pain assessment	**84**
Triage	**83**
Physiological and anatomical differences of child	**81**
Appropriate use and routes of administration	**81**
Drug dosage	**80**
Skills: -	
Rapid and accurate assessment of child	**85**
Verbal communication	**84**
Pain management	**84**
Non-verbal communication	**83**
Calculation of drugs	**82**
Administration of medicines	**82**
Administration of fluid replacement	**82**
Reassurance to child and family	**80**
Attitudes:	
Approachable to child	**84**
Good communicator	**83**
Competent	**83**
Confidentiality	**82**
Good communication skills	**82**
Caring	**82**
Non- Judgmental	**82**
Honest	**81**
Respect the needs of children and young people	**81**
Approachable	**81**
Responsive to child and family anxiety	**81**
Child Friendly	**81**
Confident to child and family	**80**
(Cont.)	
Patient	**80**
Calm	**80**
Professional	**80**
Reassuring	**80**
Supporting	**80**
Communicative to level of child	**80**
Sensitive to children's needs	**80**

Prioritisation of the physiological and anatomical differences in children together with the importance of rapid and accurate assessment including pulse rates and temperature are endorsed by the literature. Price (1994) identified the physiological variations throughout childhood that must be taken into account when accurately assessing a child. Carter (1994) and Twycross (1998) also underpin the Delphi panel findings because they were emphatic that nurses need to understand the individuality and subjectivity of pain and how this relates to the physiological differences of children. It is a unique and complicated experience for children and infants who cannot easily explain those experiences to adults.

Twycross (1998) recognised that changing practice is not easy but suggests that nurses need to become more accountable for the management of pain in children. This researcher agrees in principle but considers such accountability would be premature unless it can be demonstrated that nurses have been educated and trained to the appropriate levels of knowledge and competence. Until then, the managers who influence philosophy and attitudes should be emphasising the need for appropriate pain relief in children.

Consent issues and general observations were also considered important by the Delphi panel (being scored at 79). This is reinforced by many authors recommending the need for children's nurses to be aware that children with an appropriate level of understanding should have the opportunity to negotiate their treatment (the Gillick competence theory). Clarification is still needed about who should assess whether or not a child is sufficiently mature to make his or her own decisions. If the nurse is to carry out the assessment, or be part of the team that does so, then appropriate education is needed. In this researcher's experience, medical staff often overrule a nurse who is making these decisions because the latter often fail to understand "Gillick Law" and therefore are nervous about putting medical priorities and parent's rights

below those of children. Nurses should have a greater awareness of the legal implications of the Children Act (1989). They already have the support of recommendations from the United Nation Convention; for example it is no longer acceptable to restrain children when undergoing treatments unless it is the last resort.

The Royal College of Nursing (2000) confirmed that children's nurses should be advocates for children and should prevent fear and suffering as much as possible. The Delphi panel prioritised the corresponding attitudes and practices although they were expressed in their own words and in a variety of phrases. The attitude and approach of the presenting nurse is very important to the child and the Delphi panel recognised the great importance of good verbal communication skills accompanied by a non-judgemental attitude and being competent at all times. They considered approachability to be a high priority followed by confidentiality and respect for the child. Being responsive to the child's needs was also considered important. This supports the findings of Burgin (1993) and also Curtis, who recommended in 1983, that children's nurses should have or should develop common sense combined with insight, warmth, understanding and compassion and that their education should be structured to encompass these qualities.

It is frequently reported that staff with competence in communications will influence the rapport, trust and treatment that are both received and perceived by the child and its family. Consideration of siblings is also important. Communication at the correct level for each child is the cornerstone of quality care. The Delphi panel, in their detailed comments, supported Wood (1997) who argued that effective communication with children depends upon non-verbal as well as verbal skills. Careful listening and observation, avoidance of interference and reflection with the use of questioning are all highlighted as indicators of good practice.

Empathy and taking the other person's point of view is fundamental to communication, with the principle of respect for the child and their needs being imperative. Nurses caring for children need to be aware how children view them. Hargie et al (1994) indicated that that view would depend upon the knowledge, motives, values, emotions, attitudes, expectations and dispositions of those involved. Wood (1997) suggests that the existence or absence of these factors explain why some A and E nurses seem to be more comfortable and natural than their colleagues when dealing with children. The question still to be resolved is whether or not, and if so to what degree, such personal qualities can be developed via formal education and training.

The Delphi panel prioritised the need for the rapid and accurate assessment of children when they first enter A and E (the triage process). One practical interpretation of this is the need for training in the use of paediatric tools to aid assessment; the "coma scale" was specifically identified. Many general nurses are skilled at undertaking triage with speed and urgency in potentially life-threatening situations for children as well as adults but if the nurse does not have knowledge about the stages of a child's development then that communication may be hampered. Lenehan (1988) recognised the need for appropriately educated and experienced nurses to perform triage with children as long ago as 1988. The margin of error with children is much narrower than with adults in areas such as changes in physical status and drug dosages, all of which are age and size dependent. Even earlier, Hanton (1981) pointed out that children's nurses should be aware of normal and abnormal patterns of behaviour as a basis for assessing child or parent reactions.

Family-centred and negotiated care and child protection issues were considered important by the Delphi panel and this is reinforced by the literature. Meadows (1969), a paediatrician, was

one of the first to propose that nurses should be trained to share care with mothers and since then several authors, particularly Darbyshire (1994) have extended the concept by emphasising that family centred care should involve more than sharing simple technical tasks. He also conveyed the notion that nurses have a lot to learn from parents about the child's needs before presuming to teach them. In an A and E setting where the drama of trauma requires a speedy prioritisation of need it is not surprising that negotiated paediatric care is neglected. Parents are often not in an emotional state to make decisions. Nevertheless Philips (1994) reminds us that A and E personnel should have the attitude to involve the family in the care of their child and the Delphi panel confirmed that the notion is accepted in principle.

Child protection issues and the associated ability to identify non-accidental injury were scored 75 by the Delphi panel. These needs are strongly supported by the literature that recognises that paediatric A and E units are at the forefront of identifying child protection indicators. In that context it is perhaps surprising the panel did not give it a higher score. The DoH, in 1988 and reinforced in 1999, recommended that all nurses should work within a framework of child protection and local policies and with close adherence to procedures.

A number of specific technical skills were listed by panel members but only achieved total scores in the 40s and 50s. These skills included intra-osseous infusion, phlebotomy and venepuncture and intubation. On reflection these scores are not surprising. The reason that some of the more advanced skills did not score highly may be because the majority of the panel considered the basic skills to be more important.

Children's immune systems are still developing and the onset of illness and trauma may be sudden with children deteriorating rapidly. Extra vigilance is necessary because extremes of

heat, fluid and electrolyte loss and infection and tissue injury are not well tolerated. These facts have implications for the underpinning knowledge and skills of nurses. The Delphi panel recognised the need for vigilance to the administration of fluids.

Children suffer distress in A and E due to invasive procedures and require a great deal of understanding. These experiences remain upsetting in a child's memories for many years but kinaesthetic non-pharmacological therapies such as distraction stroking, singing, talking, and visual and interactive distraction give comfort to children under 5 years (Kurfis Stephens et al (1999) These therapies can be carried out with the involvement of parents or nurses and the value of nurses having positive attitudes to distraction through play and other therapies were referred to by many of the Delphi panel in their detailed comments. The panel also reinforced much of the literature by prioritising approachability, being responsive to the child and parent's needs and anxieties and appearing to be confident. All scored at least 80 with the need for a sense of humour also attracting considerable support. The last two attributes, supported by Hanton (1981), explain that children's nurses need to have a general love of children, a deep sense of humour and the confidence to provide support for the parents as well as the child.

It is remarkable that the Delphi panel of experienced children's nurses rated the skill of nappy changing very low (51) with only two panel members rating it as a high priority. Perhaps in A and E this skill is rarely required. It would be interesting to find out if a Delphi panel of ward based experts (rather than A and E based as in this case) would have given the same low priority. However, it might be that this skill has become a redundant skill due to the development of disposable nappies.

When the strange environments of an A and E department confront children who have little understanding they can suffer severe psychological trauma. Smith (1997) highlights the need for children's nurses to comfort, reassure, constantly anticipate and interpret the inarticulate needs of children. The Delphi panel confirm this, prioritising the need to be sensitive to a child's needs. The concerns identified by Vistainer and Wolfer (1975) should be relieved by nurses and without the corresponding understanding they are unable to do so. The Delphi panel prioritised this ability in nurses by identifying the need to respond and allay the anxieties of both children and the family.

Bentley (1996) suggested that the role of the children's nurse fits into three main categories; to assess and treat children, to be advocates for children and finally to be an educational resource, disseminating information regarding paediatric issues, health promotion and supporting the education of students. The Delphi panel did not unambiguously prioritise the advocacy role with children but did draw attention to the need to be an advocate on behalf of the parent (score 76). This could perhaps reflect the experiences of many of the panel members in working in units where the medical model predominated. Nor did the panel make reference to today's multi-cultural society. The literature underlined the importance of considering the cultural needs of ethnic minority groups, understanding and respecting their values and attitudes to childcare and health.

The findings of the Delphi study need to be taken into account when curriculum planners and professional validating bodies are designing and auditing education and training programmes for nurses who care for children in A and E. The literature indicates that many children attending A and E are currently being cared for by adult-trained nurses. Hence the Delphi

study findings should be taken into account when designing continuous professional development programmes for experienced nurses as well as for initial training.

However, if the output of the Delphi study alone was used to design the curricula, then that curricula would be very large. The actual curricula should reflect the background and experience of the nurses who undertake it. The staff survey and observations are intended to assess the actual knowledge, skill and attitudes of the nurses in practice. With that additional data, it is expected to be possible to recommend a realistic training curricula and a teaching framework using the APEL and APL systems. The APEL and APL will ensure that the existing level of competence is taken into account for each individual, resulting in a more individual, efficient and cost effective programme.

The next chapter, the responses to a questionnaire to A and E nurses working with children in three different hospitals, aims to identify any gaps in the competence and confidence of such nurses which in turn might be linked to their education and training experiences.

Chapter 7:

CURRENT KNOWLEDGE, SKILLS AND ATTITUDES OF STAFF

This chapter gives the responses to a questionnaire designed to identify the actual knowledge, skills and attitudes of nurses who are currently caring for children in A and E. It was sent to all of the qualified staff, general nurses as well as children's nurses, working in A and E in three different hospitals. Most of them have to care for adults as well as children. The questionnaire gave them the opportunity to express in their own words their current knowledge, attitudes and skills in the context of caring for children. The initial part of the questionnaire was used to collect biographical data about the respondents. This chapter presents and discusses the results from that staff survey with further discussion taking place in Chapter 9. The aim of this stage of the research was to assess the knowledge, attitudes and skill of nurses who are already caring for children in a variety of A and E settings, followed by their opinions about training for the care of children.

7.1: Response Rate to Survey

Questionnaires were sent to all of the 145 registered nurses working in the A and E Units in three different Hospitals. The Units had distinctly different characteristics, described in Chapter 6, and have been designated A, B and C. Following two prompting letters, a total of 45 responses were finally received, a rate of 31%. The response rate from each Unit is shown in Table 7.1.

Table 7.1 Response Rates from each of the A and E Units.

A and E Unit	Questionnaires Distributed	Sisters	Staff Nurses	Final Response	Sisters	Staff Nurses
A	67	n=12	n=55	15 (22%)	7 (58%)	8 (14%)
B	33	n=8	n=25	11 (34%)	5 (62%)	6 (24%)
C	45	n=10	=35	19 (43%)	6 (60%)	13 (37%)
Total	**145**	**30**	**110**	**45 (31%)**	**18 (60%)**	**27 (25%)**

The final response rate of 31% to the 145 questionnaires is not ideal according to Politt and Hungler. A response rate of less than 40% may be suspect in the context of the results being generalisable to representing the views of all of the 145 nurses working in these A and E units.

7.2 Biographical Data of the Respondents

It is interesting that 60% of the sisters that received the questionnaire did respond but only 25% staff nurses responded overall. This might suggest that the sisters were more motivated because of their interest in supporting evidence-based practice. However, when the absolute numbers of respondents are noted, there were 30% more staff nurses than sisters, amongst the respondents. Hence the raw data, which was the output of the questionnaire, is similarly weighted 3:2 from staff nurses. This should be taken into account when interpreting the data, which might reflect the training needs of staff nurses rather than that of sisters.

The nurses were asked to identify their job titles in their own words; this being the first of several questions designed to clarify the seniority and experience of each respondent. Their responses are given in the following table, Table 7.2. The job titles have been grouped by this researcher to protect the anonymity of the several respondents who quoted singular job titles.

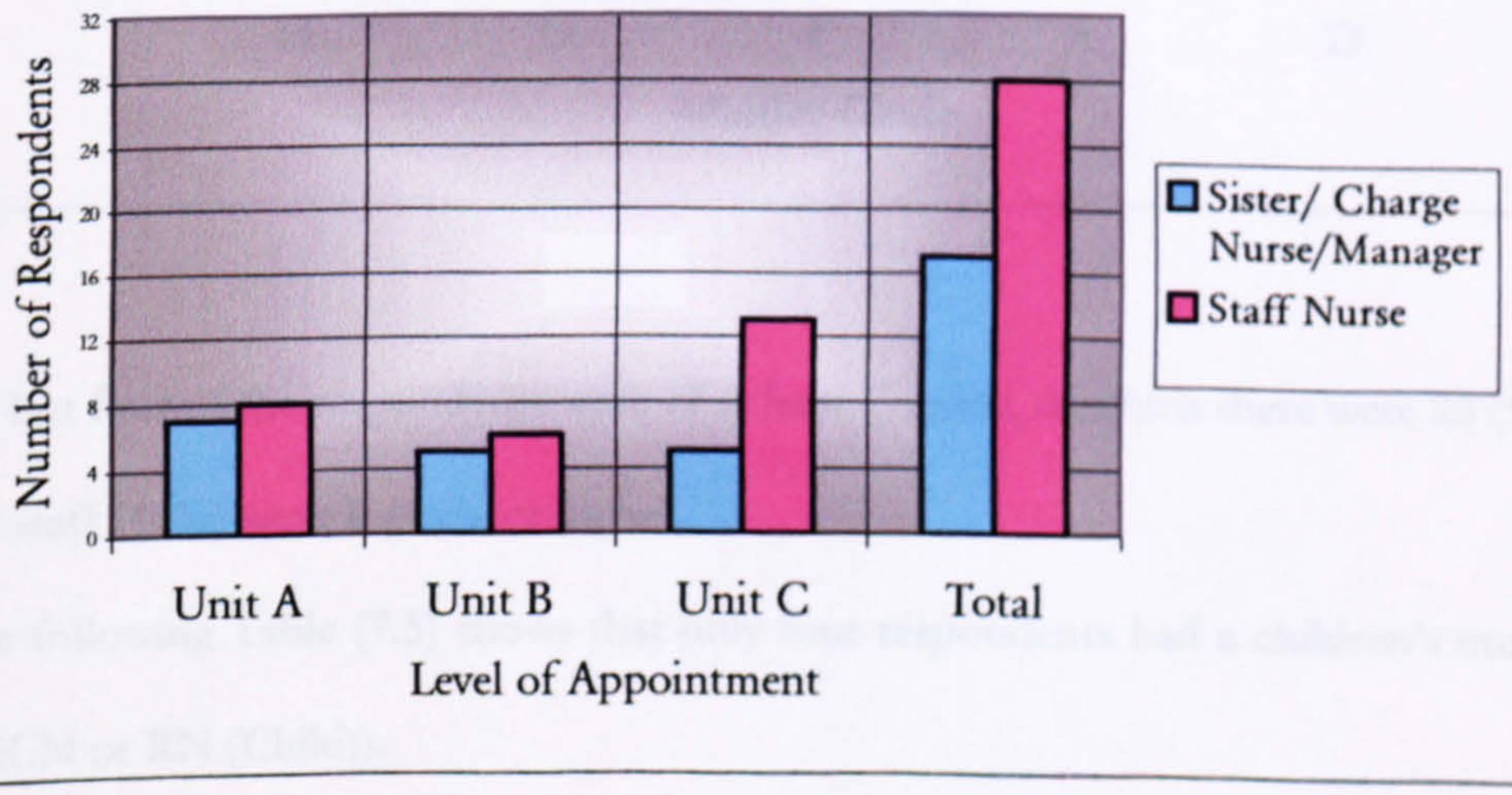
The grouping was based upon the researcher's understanding of the equivalence or similarity of seniority.

Table 7.2: The Job Titles of the Respondents

Title	Unit A	Unit B	Unit C	Total
Sister, Charge Nurse or Deputy Sister	4	5	5	14
Senior Staff Nurse	1		1	2
Staff Nurse	7	5	9	21
RGN or Registered Nurse or Nurse	2	1	4	7
Void	1			1
Total	**15**	**11**	**19**	**45**

The questionnaire sought information about their level of appointment, again using their own words. The response is shown in the following Figure, 7.3.

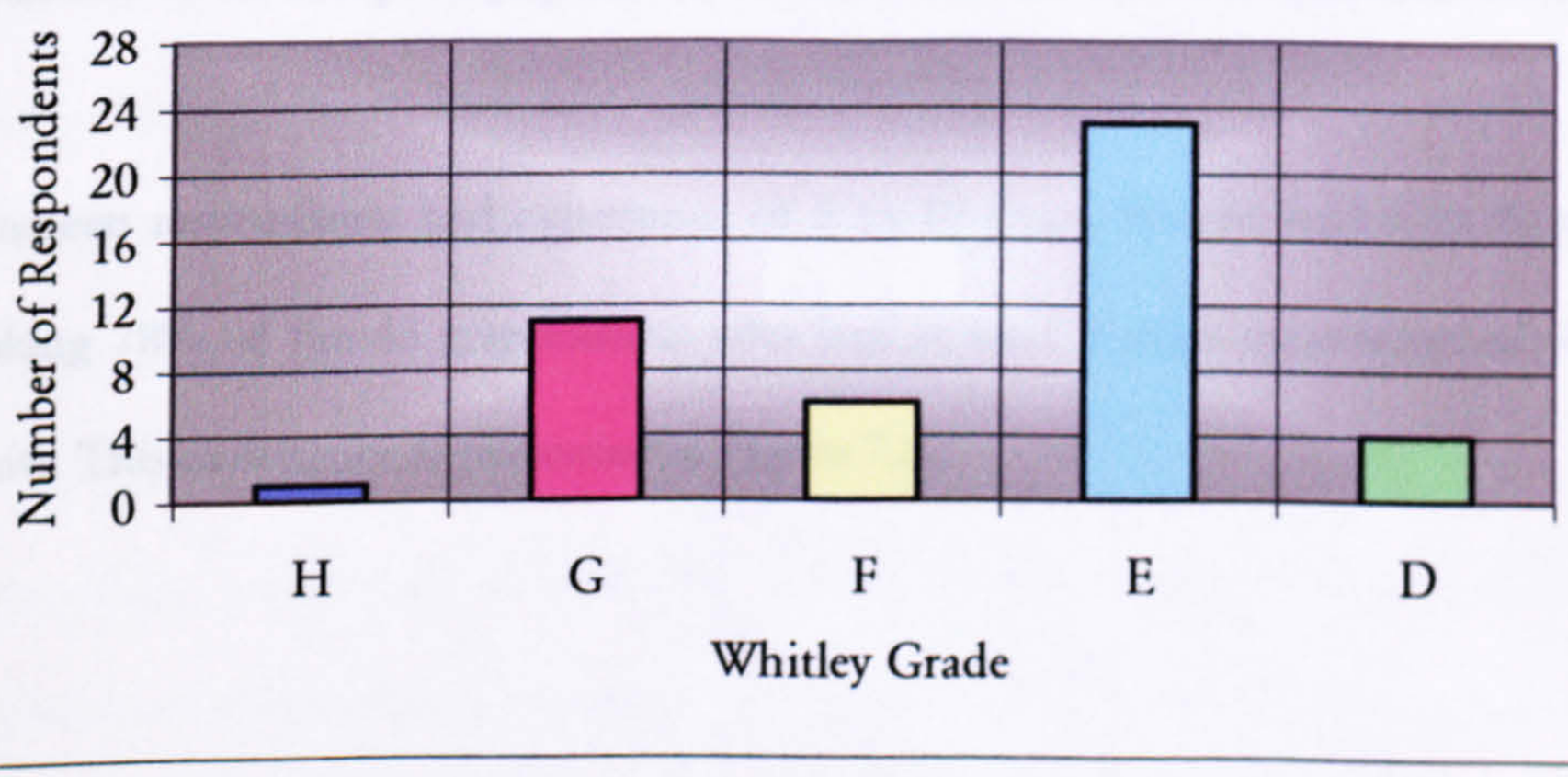
Figure 7.3: Level of Appointment



These data support the job title data given in 7.2 with one exception; seven nurses in Unit A identified themselves as sisters, charge nurses or managers. Only four identified themselves with similar job titles in 7.2. This anomaly would be explained if the two respondents who referred to themselves as "RGN" and the one void response were indeed in senior levels of appointment.

The respondents also identified their grade of appointment on the Whitley Scale. The responses range from D; the typical grade for a nurse with up to 3 years post-registration experience, up to H, which normally represents clinical management responsibilities. The results are shown in the following histogram, Figure 7.4.

Figure 7.4: Grade of Respondents



All but four of the respondents were of at least E grade, of which there were 23 (51%). Eighteen of the staff (40%) were F grade or higher.

The following Table (7.5) shows that only four respondents had a children's nursing qualification (RSCN or RN (Child)).

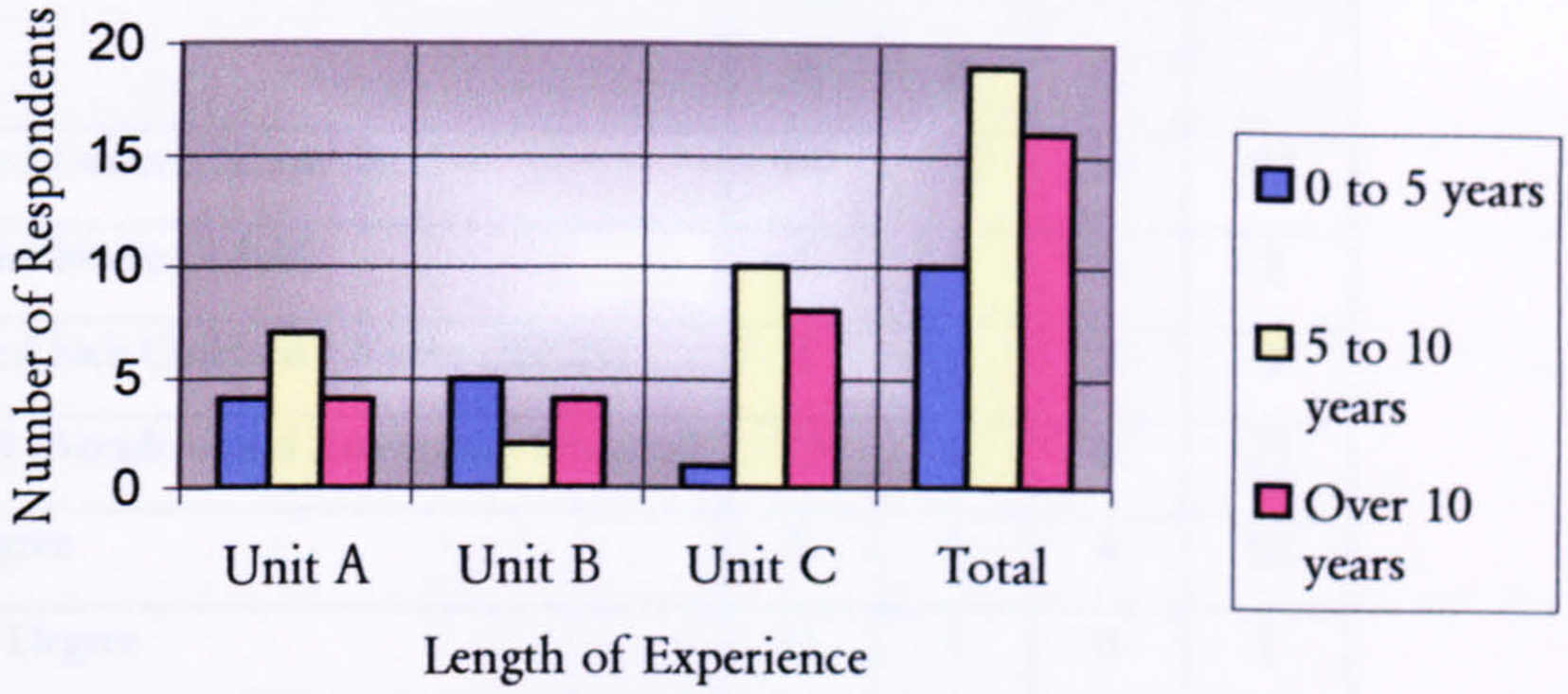
Table 7.5: Proportion of Children's Nurses

	Unit A	Unit B	Unit C	Total
RSCNs/Child Branch	1	1	2	**4**
Non-RSCNs	13	10	17	**41**

Four qualified children's nurses amongst the respondents do not reflect the total number employed in these Units. Some did not respond to the questionnaire. For example only 1 RSCN from Unit A responded and yet 6 are known by the researcher to be in employment there and 2 responded from Unit C whilst 8 are employed in that Unit. Nineteen RSCNs or RN (Child) are believed to be employed in all three Units, 13% of the population of 145 nurses, the four RSCN respondents to this survey constitute 9% of the 45 respondents. In that context therefore, the ratio of children's nurses to others who responded is a reasonable reflection of the complete population. The non-RSCNs are adult qualified nurses.

Nineteen respondents had experience of 5 to 10 years. Sixteen had over 10 years experience making 78% of the 45 respondents who had at least 5 years experience of working in these Units. This experience is presented in Figure 7.6.

Figure 7.6: Length of Experience of Respondents



The significant length of experience of most of the respondents substantiates with the seniority, as revealed by Figures 7.3 and 7.4.

Eight (18%) of the respondents were male with 37 (82%) being female. None of the male nurses were qualified children's nurses. Forty-three of the 45 respondents were Registered General Nurses with 2 Registered Nurses (Dip HE) educated to care for adults. Twenty-seven of the respondents had in addition obtained an A and E qualification (ENB 199). Eight had successfully undertaken a teaching and assessing qualification (ENB 998), whilst three had successfully completed a Paediatric Advanced Life Support course (PALS). Seventeen respondents had obtained other nursing-related qualifications. Eleven of the respondents had also obtained degrees including one at Masters level. The results are presented in Table 7.7.

Table 7.7 Qualifications of Respondents

Qualifications	Unit A	Unit B	Unit C	Total
Registered General Nurse (RGN)	14	10	19	43
Registered Nurse (Adult)	1	1	0	2
Registered Sick Children's Nurse (RSCN)	1	1	2	4
ENB 199 (Accident and Emergency Nursing)	13	6	8	27
First Degree	5	1	4	10
Master's Degree	0	1	0	1
ENB 998 (Teaching and Assessing)	2	3	3	8
Paediatric Advanced Life Support (PALS)	1	1	1	3
Other nursing related Qualifications	6	5	6	17
Total	**43**	**29**	**43**	**115**

It is revealing that of the 45 respondents, 27 (60%) had an A and E qualification, including 13 (87%) of the 15 respondents from Unit A. By comparison, only 4 (8%) respondents in total had a qualification to care for children, although all 45 had an adult nursing qualification. This response reflects a dominance in this survey sample of the general patient A and E philosophy in contrast to a conscious child care focus. This is significant when it is remembered from the literature review that about one third of the clientele in A and E are children. It is noteworthy, but not surprising, that none of the respondents had a Registered Nurses (Child) first level qualification. Such nurses might be considered by the employer to not be competent with the adult population in A and E.

Nineteen of the 45 respondents were working towards a further qualification with five working towards a first degree and four undertaking a degree at Masters level. Only three were working towards the Emergency Nurse Specialist Practitioner status, although one respondent was undertaking a suturing and cannulation course. Three staff were undertaking a Child Protection qualification (ENB 970). Three were studying for other nurse-related qualifications.

Combining the answers to question 7 and 8 revealed that, out of the total of 45 respondents, 15 had or were working towards a degree qualification including five who had already acquired or were working towards achieving a degree at Masters level. No respondent was undertaking a children's nursing qualification. This was disappointing, although any nurses away from their Unit for the purposes of such a qualification might not have received the questionnaire. The results to question 8 are presented in Table 7.8.

Table 7.8 Qualifications Currently being Undertaken

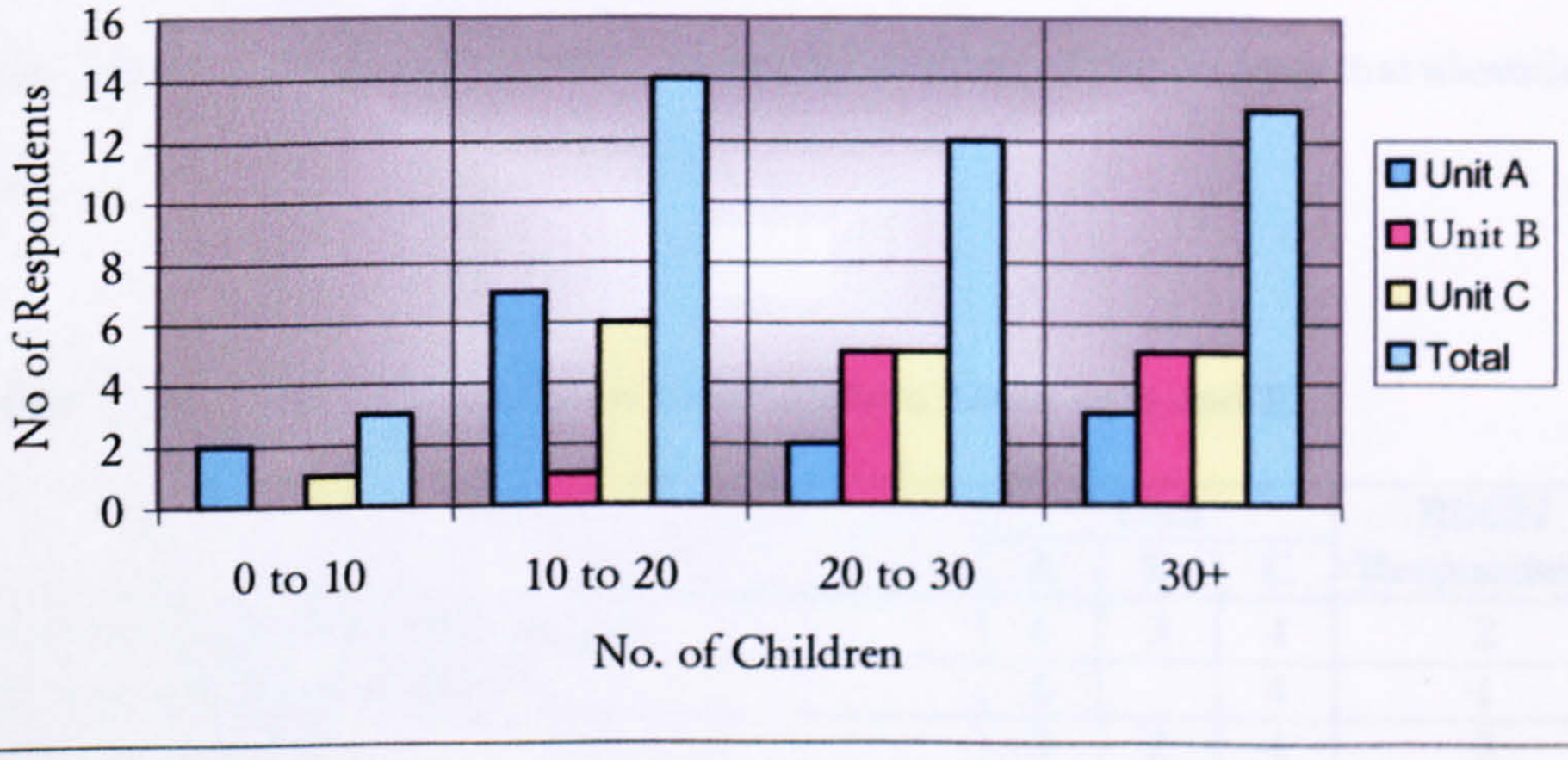
Qualifications	**Unit A**	**Unit B**	**Unit C**	**Total**
First Degree	2	3	0	5
Masters Degree	3	1	0	4
Emergency Nurse Practitioner	3	0	0	3
Suturing and Cannulation	1	0	0	1
ENB 970 (Child Protection)	1	0	2	3
Other Nurse related Qualifications	0	1	2	3
Total	**10**	**5**	**4**	**19**

The development of nursing in becoming a profession for degree-level staff is reflected by 10 respondents having achieved such a qualification (Table 7.7) with 5 more working towards a degree (Table 7.8). Hence 33% of all of the respondents have or will have a degree and

presumably are now, or will soon be, working at degree level in practice. However the number of staff qualified to care for children, or seeking such a qualification is disappointing. If as appears to be the case, a degree is attractive to nurses, then perhaps a degree with child specific modules as options could be made more available.

The survey then sought to identify the number of children cared for by each respondent each week. The results are presented in a histogram in Figure 7.9.

Figure 7.9: No. of Children Cared for in a Week



The number of children cared for by each respondent each week varied considerably but 26 of them (56%) dealt with between 10 and 30 and 29% of them cared for more than 30. Three responses were spoilt. Almost all of the respondents considered that children required specific nursing care with 42 respondents responding 'yes' and only 2 responding 'no'. The latter two respondents, who considered that nursing care of children in A & E was no different to that of adults, were both from Unit C. Unit C is a District General Hospital. One response was spoilt.

7.3 Nurse Attributes identified by the Survey.

The remaining seventeen questions sought a variety of information, most of it qualitative, about the nurses' perceptions of the attributes needed to care for children in A and E and of their own competence. It is the combination of answers to the following questions, combined with the results of the observations presented in the next chapter that reveal their actual knowledge, skills and attitudes.

Staff were asked to detail the nature of the specific care that most of them had confirmed (in their answer to question 10) to be necessary for children in A and E. They responded in their own words, usually as phrases or short sentences. Their responses have been categorised in Table 7.10. The numbers in Table 7. 10 are the number of respondents that identified each care issue.

Table 7.10 The Types of Care that Children Need in A and E

	Unit			RSCN Respondents	Total
	A	B	C		
Different/Special/Specific/ unique	6	3	4	2	13
Safety and child protection	5		4	1	9
Family centred care	3	2	4	3	9
Calm, patient, different approach	2	5		1	7
Environmental influences	1	1	3	1	5
Use of play and distraction therapy	1	2	2	2	5
Anatomical and physical differences	1		3		4
Behavioural, emotional and psychological differences		2	2	2	4
Weight differences and drug calculations		1	2	1	3
Appropriate to development	2			2	2
Rewards and tactile care		1	1	1	2
Health promotion and education		1	1		2
Paramouncy (Needs are paramount)		1		1	1
Pain			1	1	1

It is surprising that the four "RSCN" respondents did not each identify the majority of the specific types of care needed. This may be attributed to the time factor of fully completing the questionnaire, or perhaps it reflects the A and E culture and philosophy in which they are practicing.

The tabulated care issues are necessarily abbreviated from the raw data from individual responses but they are meaningful to the researcher, ensuring that their range as well as their weighting will be taken into account when all the results are discussed. These data are a source of rich information; illustrated by listing some of the individual responses completely. That children are different and need specialist care was clearly understood by some of the nurses who said the following: -

> "Children are not small adults"
>
> "From close observation, their condition can be quite "votile" [sic –volatile?], children can go off very quickly. They do not act rational, so it is best to keep an eye on the child. I always work with a high index of suspicion in relation to children and their mechanisms of injury".
>
> "Children require specific waiting areas and treatment areas and staff with recognised training".
>
> "I believe nurses who have specialist paediatric qualifications should care for children"

But not all the nurses subscribe to these views.

> "I don't feel you need to be an RSCN to be a better nurse to care for children rather than a general nurse"

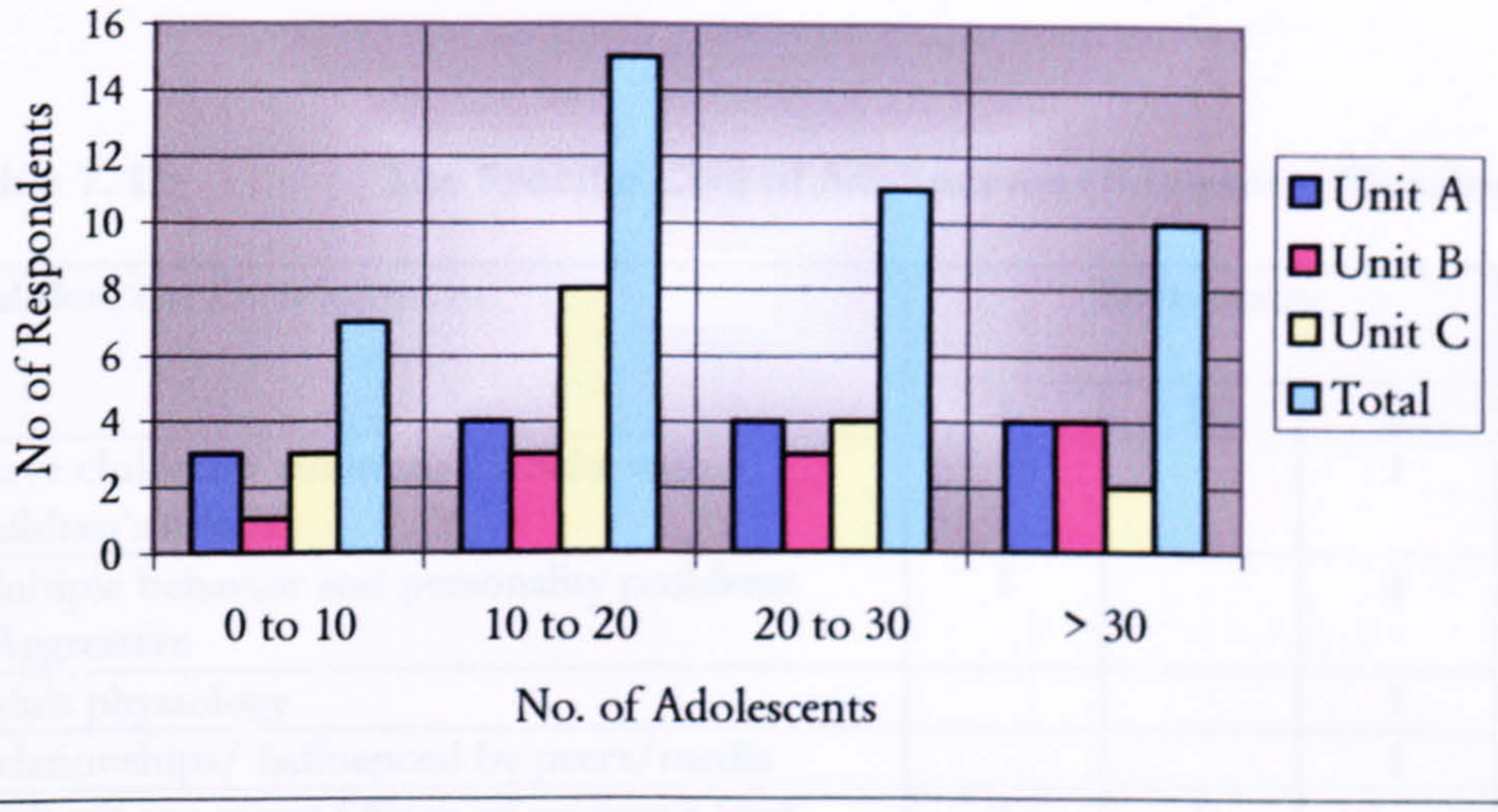
"Regardless of the age of patients they should be assessed and treated accordingly, providing the nurse has the adequate communication and life skills—"

"Because they are children, children are a priority but not at the expense of the elderly"

When asked about their ability to meet the specific needs of children in A & E, none of the respondents considered themselves to always meet the specific needs of children but the significant majority (89%) consider that they mostly met those needs. However three considered themselves to only meet those needs sometimes and two considered that they never did. One response was spoilt.

The respondents were asked to estimate the number of adolescents they cared for in a typical week. The term "adolescent" was deliberately not defined. They had been asked the same question, but about children, in question 9. Two responses were spoilt. The responses are presented in Figure 7.11.

Figure 7.11: No of Adolescents Cared for in One Week.



Twenty-six of the respondents (58%) dealt with between 10 and 30 each week. Exactly the same number said they dealt with the same number of children. Ten of them cared for more than 30 adolescents each week; compared with thirteen who dealt with more than 30 children. The similarity between the numbers might reflect the actual situation; that there is a similar throughput of adolescents and those under (say) 14 years only. It might also mean that the respondents could not or do not separate pre-adults into the two categories. The number of adolescents dealt with by individual nurses, if they have properly distinguished adolescent from younger children, might reflect the case load selection according to their likes and dislikes of caring for adolescents. Thirty seven (84%) of respondents considered that specific nursing care was needed when caring for adolescents in A and E, although six were unsure and one disagreed. One response was spoilt. Staff were requested to expand upon their response to question 14 by listing, in their own words, the specific needs of adolescents when cared for in A and E. The responses were more diverse with little consensus, in contrast to the answers about the care of children. Hence it was difficult to reduce the responses into categories which could be presented in a single table. The responses are given in the Tables 7.12 to 7.15; each

being a categorisation of the answers into one of the following themes: adolescent development, adolescent needs, specific nursing care, communication and attitudes.

Table 7. 12: The Specific Care of Adolescents (Adolescent Development)

Adolescent Development	Responses			Total
	A	B	C	
Have children's emotions /Adults with children's minds	1		1	2
Multiple behavior and personality problems /Aggressive	1		1	2
Adult physiology			1	1
Relationships/ Influenced by peers/media			1	1
Difficult age group/ Stage of no man's land	1	1		2
Speak own language	1			1
Difficult time/mood conflict/ Hormonal changes	2	2	1	5
Not small adults/ Neither child not adult	4	2		6
Difficult period physiologically and psychologically	1			1
Vary in reaction/response to illness/ trauma		1		1

Individual responses included adolescence being a difficult time with mood conflict, children's emotions and multiple behaviour and personality problems. Adolescents have an adult physiology but also experience difficulty developing adult relationships. Other individual responses reflected it being a difficult age group, being influenced by peers, a time of aggression and at a stage of "in no-man's land". They were likened to adults with children's minds, a difficult period for them both physiologically and psychologically. Various reactions and responses to illness and trauma referred to the adult physiology and one individual considered that they speak their own language, which could indicate communication problems when caring for adolescents in A and E.

Table 7. 13: The Specific Care of Adolescents (Adolescent Needs)

Adolescent Needs	Responses			Total
	A	B	C	
Independent/individual/different needs	3	1	1	5
Understanding of needs	3	1	1	5
Bigger underneath problems	3	1	1	5
Partnership and parental/guardian involvement			3	3
Family dynamic issues	1		2	3
Recognition of dignity/ status / credibility	1		2	3
Health care needs	1	1		2
Morning after pill	1		1	2
Needs not met in children's area	2			2
Recognition of privacy	2			2
Environment	1		1	2
Need for space				
Specific health care needs	1	1		2
Perceptive to needs		1		1
Need for distraction/video/books/game boy	1			1
Different psychosocial needs			1	1
Need choices/ decisions along with parents		1		1
Responsibility / autonomy		1		1
Need to express fears/ anxieties/ opinions		1		1

Reflecting upon adolescent needs, five respondents considered that they were independent in their behaviour and individual in character with five recognising that adolescents needed to be understood. Of particular interest was that five respondents considered that adolescents often had bigger underlying problems than those they presented to A and E. Three respondents considered that partnership and parental or guardian involvement in care was necessary, three more that family dynamic issues were important and that dignity, status and credibility were significant for adolescents. Other opinions related to the health care needs of adolescents, especially to the morning after pill, and that such needs were often not met in a children's area. The need for adolescents to have privacy during their care and for that care to be in an adolescent–friendly environment was also stated.

Table 7. 14: The Specific Care of Adolescents (Nursing Care)

Specific Nursing Care	Responses			Total
	A	B	C	
Identify/assess level of understanding and address appropriately	2	2	1	5
Up to date knowledge of youth culture/ being in touch/right level	2	1		3
Time/input more		1	2	3
Recognise ethical dilemmas in general			3	3
Recognise ethical dilemmas- pregnancy/alcohol/drugs			3	3
Aware of emerging ethical dilemmas	1		2	3
Aware of child protection issues	2			2
Aware of legalities	2			2
Confidentiality	1		1	2
Knowledge of resources and referral agencies	1		1	2
Gain confidence/trust		1	1	2
Health education and promotion activities			2	2
Aware of needs	1			1
Confidence in dealing with problems	1			1
Emotional issues dealing with overdoses			1	1

Three respondents commented that ethical dilemmas were likely when caring for adolescents but did not elaborate. It was suggested that nurses need to be up to date in their knowledge of youth culture. Three respondents wanted more time for adolescent care and five considered it necessary to identify and assess the level of understanding of adolescents. Other opinions included the need for health education and promotion (but were not specific) and for a better understanding of the emotions of adolescents who have overdosed on drugs and alcohol.

Table 7. 15: The Specific Care of Adolescents (Communication and Attitudes)

Communication and Attitudes	Responses			Total
	A	B	C	
Emotional support	1		3	4
Sensitive			2	2
Flexible	1		1	2
Adaptable	1		1	2
Being in touch/same level		2		2
Not patronising			2	2
Listening ear	1			1
Sympathetic	1			1
Empathy	1			1
Good interpersonal skills	1			1
Perceptive to needs		1		1
Different approach	1			1
Support to talk freely		1		1
Talking to not down to		1		1
Reassurance		1		1
Explanations commensurate to age			1	1

Communication and attitudes, thought to be appropriate for nurses dealing with adolescents, included emotional support, sensitivity, flexibility and being adaptable. Further responses included the need to not patronise, be a listening ear, be sympathetic, empathetic, have good interpersonal skills and be perceptive to their needs. Opinions were also expressed about the need to offer adolescents support, talking freely and not down to them with plenty of reassurance and explanations commensurate with their age.

One respondent, an F-grade Sister with 5-10 years of experience quoted,

> "I find adolescents quite difficult at times in caring for them, but I feel this is a lot to do with their attitude and that they think they are adults. I do enjoy looking after them a bit. I am not sure what specific training is required to enable me to improve in this area."

An initial response to one of the questions, before it was actually answered by a G-grade Sister with over 10 years experience, was:

> "You have to be a mother of an adolescent to answer this."

Another G-grade sister with over 10 years of experience and who was unsure as to whether or not she is meeting the needs of adolescents answered:

> "Unsure how to answer this one. Very individual cases – in trying to achieve a holistic approach to everyone, no matter what age, everyone would have specific nursing care to them".

Overall there did appear to be a general recognition that adolescents were different, that their needs were not specifically met in either a children's or an adult unit, and that adolescence was the transition phase. As one G-grade Sister said:

> "Transition phase for patient - appropriate approach and recognition of their individuality whilst addressing parents' concerns and guardianship issues."

An interesting quote from a qualified RSCN Staff Nurse with over 10 years experience recognised the following:

> "Spending time to elicit their level of understanding, appreciating that they are growing up and wanting to take more responsibility and autonomy for themselves, and yet allowing them to express their fears and anxieties with privacy. Building up trust, pitching explanations at their level, and allowing them to make choices and decisions for themselves, within reason. Also appreciating hormonal changes and mood conflict."

One quote almost certainly recognised their needs are different from both the child and the adult:

> "Whereas they do not need as much input as a child, I believe they still require more input than adults. Many adolescents become/revert into younger children in times of stress/pain etc."

A number of respondents from Unit C, the unit in a District General Hospital, did not feel a need to provide a list of specific care needs of adolescents and one of them said:

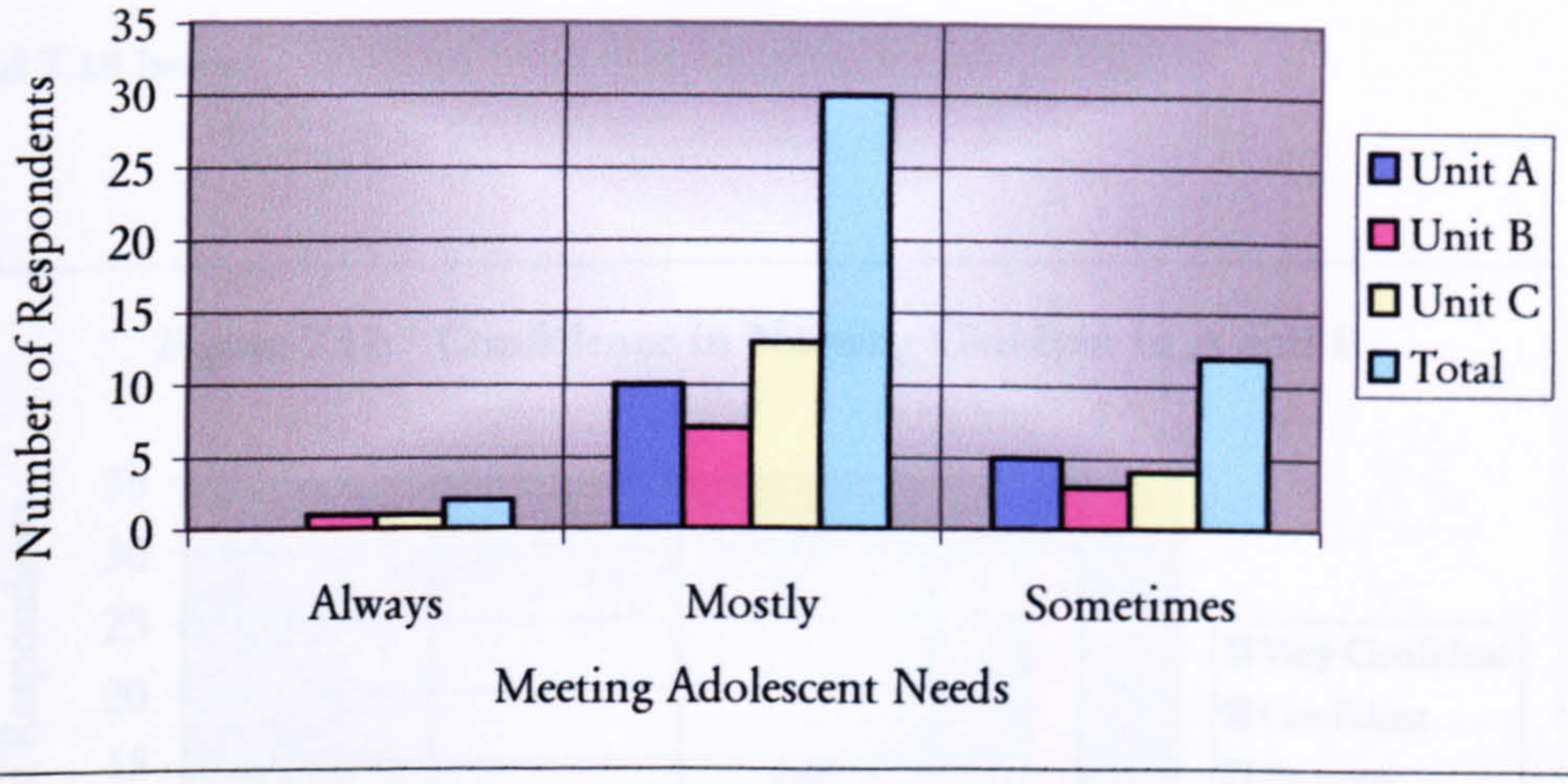
> "See answers to 11 – the same as for the care of children."

One G-grade Sister with over ten years experience recognised some of the specific problems with adolescents and quoted:

> "Childcare – safety issues arise. Consumption of alcohol, taking of drugs, problems particularly seen in A& E, emotional issues dealing with overdoses, aggression dealing with sexual issues, e.g.: underage pregnancy, morning-after pill."

The nurses were asked whether or not they considered that they met the needs of the adolescent in their care in A and E as presented in figure 7.16.

Figure 7.16: Meeting the Specific Needs of Adolescents

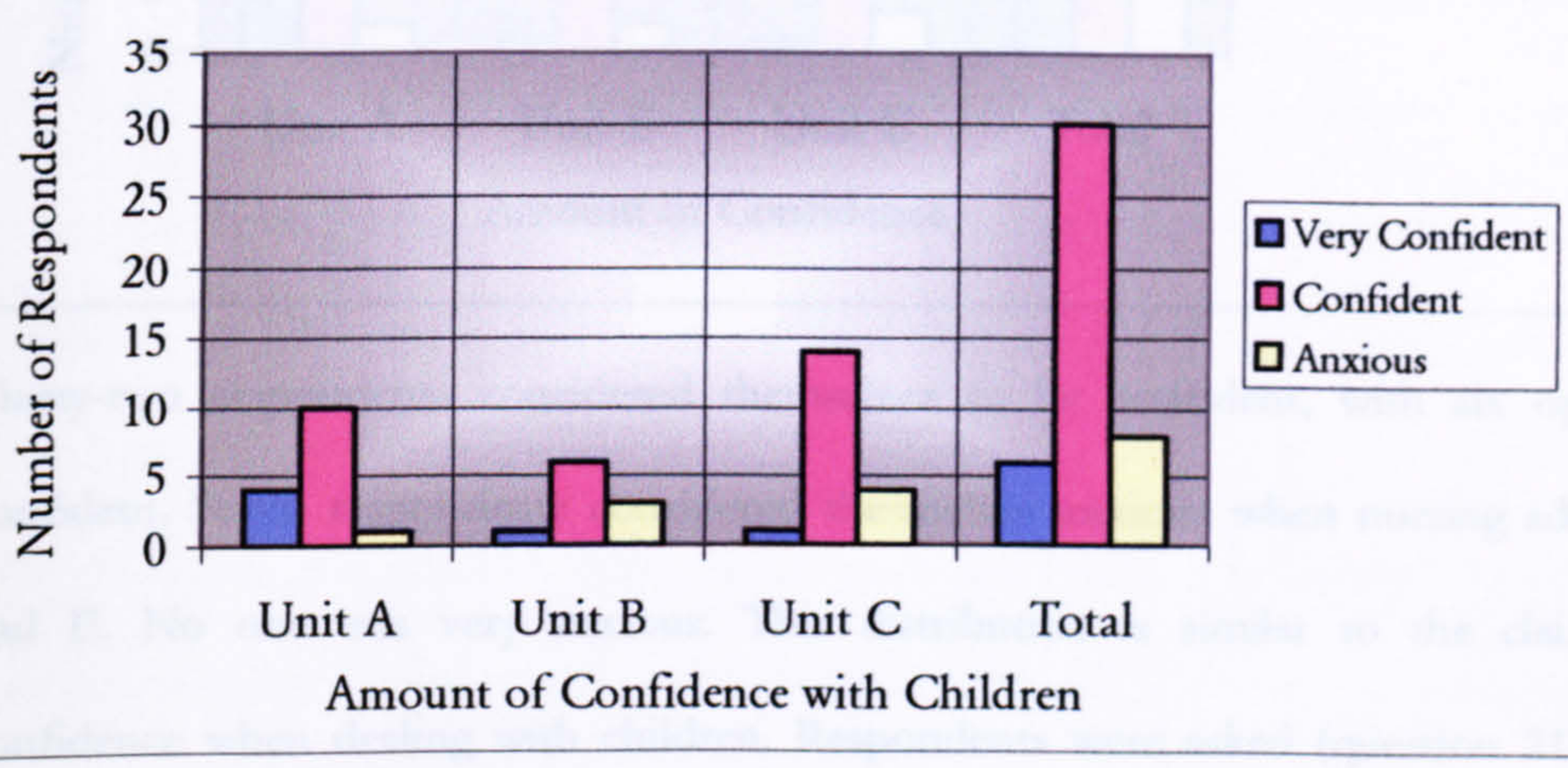


Two respondents (both from District General Hospitals) thought they always met the needs of adolescents with the majority (67%) believing that they mostly did. A significant minority (27%) said that they only met the needs of the adolescents in their care "sometimes". There was one spoilt response.

A further question asked the nurses to indicate the levels of knowledge they have to enable them to care for children in general. The majority of respondents (67%) considered themselves to be quite knowledgeable. Eight respondents considered themselves better than that with seven considering themselves less so. This question was the same as question 17, but seeking the self-perceptions of the knowledge levels of the nurses in the contexts of dealing specifically with adolescents. The patterns of the responses were similar to the previous question for children in general (question 17). The majority (73%) considered themselves to be quite knowledgeable with four considering themselves very knowledgeable and six not very knowledgeable.

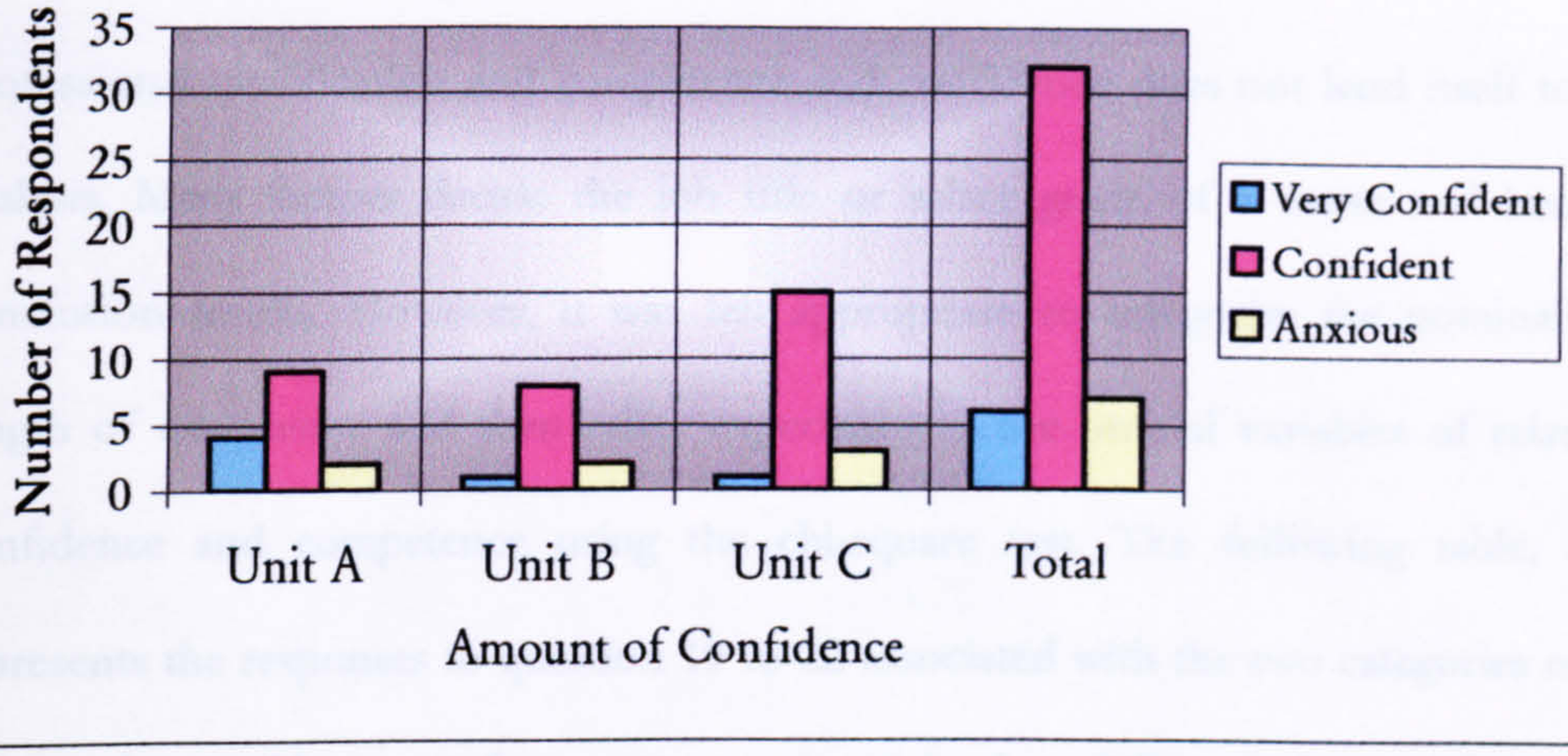
The next two questions (nos. 19 and 20) asked nurses to comment on their level of confidence caring, firstly for children and then for adolescents. The results are presented in Figures 7.17 and 7.18 below.

Figure 7.17: Confidence in Nursing Children in A and E



Thirty respondents (79%) to question 19 considered themselves "confident" when caring for children with six (13%) considering themselves very confident. It is interesting that eight (18%) felt 'anxious' about caring for children in A and E. No one was very anxious. One nurse did not answer the question. The same question was asked to the nurses, specific to caring for adolescents. The results are presented in Figure 7.18.

Figure 7.18: Confidence in Nursing Adolescents in A and E



Thirty-two respondents considered themselves to be confident, with six opting for very confident. Seven respondents considered themselves anxious when nursing adolescents in A and E. No one was very anxious. This distribution is similar to the claimed levels of confidence when dealing with children. Respondents were asked (question 21) to self-grade their competency when nursing children in A and E. Twenty-seven (60%) considered themselves competent, with eight more (18%) considering themselves very competent. The remaining ten indicated they are "quite competent". No one graded themselves as incompetent. Having self-graded their competence in caring for children in A and E the nurses were asked for the same information (question 22) but specific to adolescents. Twenty -eight (62%) opted for competent with eight more grading themselves very competent and nine considering themselves "quite competent". No one admitted to incompetence. Again (as for question 19 and 20) the pattern is the same as the corresponding question about children.

The responses to questions 19 to 22 about competence and confidence led the researcher to speculate about possible links between their responses and either a direct or indirect measure of their knowledge, skills and attitudes: links which might be tested by statistical analysis.

Qualifications should relate in some measure to knowledge, skills and attitude but, as only four RSCNs responded out of a population of 45 qualified nurses, the links between professional qualification and competence and confidence does not lend itself to quantitative analysis. Many factors decide the job title or salary grade of a nurse and hence the same conclusion results. However, it was felt appropriate to categorise the nominal variables of length of experience and then relate experience to the ordinal variables of relative levels of confidence and competence using the chi-square test. The following table, (Table 7.19) represents the responses to question 19 to 22 associated with the two categories of responding nurses; those with up to five years experience in A and E and those with over five years experience.

The chi-square is a non-parametric significance test which may be used to test the expected frequencies of two types of respondents (those of "more" or "less" experience) and compares the observed frequencies in each of the four Likert scale categories with the expected frequencies if the differences are due to chance.

Table 7.19 Distribution of Self Stated Levels of Competence and Confidence of Nurses who Care for Children and Adolescents.
(Distributions are given for two levels of experience.)

Caring for Children	Very Competent	Competent	Quite Competent	Not Competent	Marginal Totals	Chi-Square Value
Group1 A and E nurses 0-5 years experience	0	5	5	0	10	5.88
	E=1.78	E= 5.78	E= 2.44	0		
Group 2 A and E nurses over 5 years experience	8	21	6	0	35	
	E= 6.22		E= 8.55	0		
Total	**8**	**26**	**11**	**0**	**45**	

Figure 7.19 Continued.

Caring for Adolescents	Very Competent	Competent	Quite Competent	Not Competent	Marginal Totals	Chi-Square Value
Group1 A and E nurses 0-5 years experience	1	5	4	0	10	5.85
	E= 1.78	E=6.44	E=1.78	0		
Group 2 A and E nurses over 5 years experience	7	24	4	0	35	
	E= 6.22	E= 22.56	E= 6.22	0		
Total	8	29	8	0	45	

E = Expected Frequency.

Caring for Children	Very Confident	Confident	Anxious	Very Anxious	Marginal Totals	Chi-Square Value
Group1 A and E nurses 0-5 years experience	0	7	3	0	10	4.31
	E= 1.33	E= 6.89	E=1.78	0		
Group 2 A and E nurses over 5 years experience	6	24	5	0	35	
	E= 4.67	E=18.67	E=6.22	0		
Total	6	31	8	0	45	

Caring for Adolescents	Very Confident	Confident	Anxious	Very Anxious	Marginal Totals	Chi-Square Value
Group1 A and E nurses 0-5 years experience	1	6	3	0	10	2.03
	E=1.33	E=2.11	E=1.56	0		
Group 2 A and E nurses over 5 years experience	5	26	4	0	35	
	E=4.67	E=24.89	E=5.44	0		
Total	6	32	7	0	45	

E = Expected Frequency

Each box shows the number of nurses who responded and the E value, calculated according to the Chi-square analysis, (Greene and D'Oliveria, 1989, pp 69-73) which represents the expected number of nurses if the differences between the distribution of competence or confidence for each group of nurses is due to chance. The chi-square values for each distribution are also shown in Table 7.19. These values were compared with critical values at various levels of probability using a standard statistical table. There are two degrees of freedom for the data in Table 7.19.

The critical value of chi-square at the probability level of 0.5 for the degrees of freedom is 5.99. This is slightly higher than the computed values for the two "competence" distributions and much higher than the computed values for the "confidence" distributions, particularly when dealing with adolescents. Indeed the latter value (2.03) is less than the 4.60 critical value for chi-squared at a probability of 0.10.

The test compares the actual number of nurses that fall into each square in Table 7.19 with the numbers that would be expected if there were no differences in the competence or confidence distributions of the two categories of nurses, whether caring for children or adolescents. It also determines whether differences are likely to be due to chance. The 5.88 and 5.85 computed values mean that the probability cannot be rejected, that the competence distributions are due to chance, although the probability factor is close to 0.05. The biggest differences between the actual number of nurses and the expected numbers (the E value) is for nurses who claim to be confident caring for children; the number being 24 and 18.67 respectively. This is unlikely to be significant in view of the chi-square value for these distributions. In summary, this statistical

analysis has been an interesting exercise but has added very little value to the analysis of the survey results.

The respondents were asked (question 23) to identify, in their own words, the skills they use when nursing children in A and E. There were some 165 different answers; mostly referring to skills but some also referring to attitudes or knowledge. In addition there were four references to the need for a safe and private nursing environment for children and eleven references to specific training courses.

The distribution of the 165 responses, between topics from the three different A and E units, is shown in the following table, (Table 7.20).

Table 7.20: Skills Used when Nursing a Child in A and E.

Type of Responses	No. of Responses from each Unit.			Total no. of Responses
	A	B	C	
Assessing child development; theoretical, physiology, testing.	4	0	0	**4**
Communications; interpersonal, listening, verbal and non-verbal, comforting, eye contact, direct and indirect questions, ensuring understanding.	6	13	14	**33**
Observations; physical, social, psychological, behaviour, distress, interaction with carer, of play.	7	1	1	**9**
Child Care Skills; pain assessment, play therapy, size and weight measurement, drug calculations, urine samples, advice on health and safety, child empowerment.	8	8	10	**26**
Family-centred care; support for and involvement of parents and child, counselling and teaching parents.	1	4	4	**9**
Child Protection.	1	4	4	**9** (cont.)

Table 7.20: Skills Used when Nursing a Child in A and E. (Contd.)				
Trauma skills; triage and prioritisation, suturing and managing wounds, plastering, treatment of injuries, experience of A and E.	10	9	12	**31**
General skills; management and documentation, numerical, referral to others, teamwork, following policies.	11	2	14	**27**
General knowledge and experience; of life, motherhood, of the unexpected.	1	3	1	**5**
Attitudes; honesty and humour, reassurance and praise, patience and confidence building, gentle and non-threatening, empathy, understanding and common sense.	6	9	9	**24**

Only four respondents (all from unit A) considered the skills for assessing child development as significant, but communication skills were identified thirty three times as necessary for the care of children including ten who acknowledged the importance of listening skills. Observation skills were highlighted by nine especially those relating to psychological and social behaviour and the distress of a child. The interactions between child and carer as well as observations of play were also mentioned.

There were twenty-six references to skills specific to nursing children in general, and thirty-one references to a wide range of trauma skills. Eight of the latter drew specific attention to triage and prioritisation. There were also a significant number of references to general skills such as documentation and teamwork, which are necessary to support direct caring activities.

Family centred care was highlighted by nine respondents but only one recognised awareness relating to child protection issues. Four recognised the need to involve parents with two acknowledging that effective counselling skills with parents were necessary.

Several drew attention to the value of their knowledge and experience of life in general and motherhood in particular and twenty-four commented on positive attitudes and empathy in caring for children. Honesty, humour, reassurance, reward and praise were all considered to be important, together with patience, nurturing, sensitivity, a non-threatening approach and "getting down to their level". It is difficult to understand whether this means to make appropriate eye contact or whether to communicate at a child's level of understanding.

Eleven responses, including seven from Unit A, referred to specific training courses that had helped develop their skills. They were the childcare course, undertaken specifically in Units A and B, Registered Nursing Mental Health, Paediatric Advanced Life Support (PALS) and the Accident and Emergency Course (ENB 199). Study days also featured.

Some of the actual responses to the question "What skills do you currently use when you are nursing a child in A and E" will now be given. They illustrate the diversity of the responses and add a "colour" or richness to Table 7.20.

"all of my skills"

"personal skill"

"previous skill"

"knowledge through experience as a nurse, mother and grandmother"

"the knowledge of my own daughter's needs and mothering skills"

"a perception of life"

"be aware of the unexpected"

"the skills of knowledge".

One respondent thought the skills were "innumerable" and another "the same as adult nursing".

The following remarks conjure up a feel for the majority of the responses.

"All the nursing experience gained from Care of the Child Course. I do have to think more when caring for children."

"I do use the resources of other staff members more experienced in this field".

A qualified children's nurse who was working as an F grade sister and who had more than ten years experience, summed up her different skills as follows:-

"Triage and assessment
Effective referral to other professionals e.g. Child protection, HV school nurse, GP Practice nurse, child and adolescent psychiatry
Accurate measuring and recording of weights, heights, length, urine samples and testing.
Drug calculations
Utilising play and distraction
Suturing plastering nurse practitioner
Assessment of developmental skills
Advice giving on health, diet, sleep problems
Health and safety advice
Completion of "red book"
Support to parents and other family members."

Other children's qualified nurses (RSCN) said:

"A gentle approach, appreciating a child is fearful of the alien surroundings
I am aware that I change the pitch and tone of my voice
I dip down to their height to make eye contact
I ask the child what has happened and try and engage them, rather than just talking with the accompanying adult initially.
Simple explanations, ensuring that the child understands through feedback, and involving play with toys and distraction where appropriate
Simple explanations of what is going to happen and why, ensuring that the child understands through feedback
Involving play with toys and distractions where appropriate."

However, one nurse responded;

'I haven't got time to complete all these boxes – too lengthy for a questionnaire.'

The following question was the same as question 23 but in this instance seeks information about the skills used in nursing adolescents rather than children. On this occasion there were 144 items listed and these are summarised in the following Table 7.21. In addition there were four references to the need for an appropriate environment within A and E and nine references to training courses for the acquisition of skills.

Table 7.21: Skills Used when Nursing an Adolescent in A and E

Type of Responses	No. of responses from each Unit.			Total no. of Responses
	A	B	C	
Communications; interpersonal, verbal and non-verbal, listening, counselling, establishing rapport, negotiating and offering choices, empowerment.	16	12	29	**57**
Adolescent care skills; clinical and pain assessment, assessment of maturity and confidence and family dynamics, diversional therapy, privacy, mothering skills, as for adults, teaching parents, sexual awareness.	8	7	18	**33**
Family-Centred care.	0	0	3	**3**
Trauma skills; plastering and suturing, local anaesthetics, venepuncture and cannulation	5	0	0	**5**
General skills; management, documentation, referral to agencies, numerical.	3	2	6	**11**
General knowledge and experience; of adolescent developments, bullying sand safety issues, nursing models, physical parameters.	5	4	3	**12**
Attitudes; respect, tact, dignity, non-judgemental, honesty, patience, reassurance, humour.	8	1	14	**23**

Fifty-seven of the responses identified a wide range of communication skills with verbal and non-verbal skills being listed ten times and with thirteen references to listening. There were thirty-three references to skills that appeared to be specific to the care of adolescents although there were three unambiguous comments that the skills needed were the same as for adults. References were made to the importance of empowerment alongside adolescent centred care with the need to give credibility and status to the adolescent as well as reassurance and being non-judgemental.

Two respondents from Unit A considered that the *Care of the Child in A & E* course had given them essential and necessary skill. Others quoted the values of the Mental Health Course, Paediatric Airway Life Support (ATLS or PALS) courses, Trauma training courses and the Specialist Nurse Practitioner module.

Interesting individual responses are now quoted to add value to the foregoing table and to illustrate the diversity of style of the individual responses as follows. The first four quotes clearly recognise that adolescents have distinct characteristics and communication needs.

> "Offer choice do you want to go to children's A/E area or Adults.
> I do find them more challenging to care for, but believe in letting them, helping them make choices re there [sic] treatment and care, guiding them where possible".

> "As for children but more so and tact, diplomacy, non-judgemental, open minded."

> "If I am worried about from the above that I am not being told what the real problem is, but sense they want to tell me, I may broach this with them."

> "Communication – listening".

A qualified children's nurse (RSCN) summed up her awareness of adolescents as follows:-

> "I intend to gain/win the confidence of the adolescent by engaging in conversation with them appropriate to their developmental age and assessed level of understanding. Employing negotiating skills in order to allow them to make informed choices in their own care (present condition permitting). Also appreciating their right to privacy in order to maintain dignity. Utilising previous knowledge and experience of normal parameters of blood pressure, pulse resps. and temperature in order to make a complete assessment of the adolescent".

But not all of the respondents recognised distinct differences between adolescents and other patients and hence did not appear to believe that special knowledge or skills was necessary.

"More or less same as for adults."

"Treat them as an adult if they are able to understand"

"My full range of skills,"

"A wide variety of skills,"

"All skills that are used as a nurse in this acute setting of A and E incorporating the nursing process model and philosophy used in this A/E" (Unit C).

"Common sense involving parent in care; Humour; Patience"

7.4 Desired Skills to Care for Children in an A and E.

The nurses were asked to identify the skills they would particularly like to develop if they were to go on a course to improve their ability to care for children in A and E.

There are 105 separate responses of which about 33 referred to desirable knowledge rather than skill. The paediatric nursing skills can be categorized as either general or those specific to A and E. The responses are given in Table 7.22.

Table 7.22: Desired Skills (and Knowledge) to Care for Children in A and E.

Desired Skill	No of Responses from each Unit			Total No. of Responses
Paediatric General:	**A**	**B**	**C**	
Drug dosages/paediatric medicines		3	4	**7**
Holistic care of child and family.	1	2	3	**6**
Child abuse/NAI/child protection /physical abuse. Sexual abuse/ offending adult	3	1	4	**6**
Assessment of ill child		2	1	**3**
Communications.	2	1		**3**
Play.		1	1	**2**
Neonatal/premature babies and toddlers.	1	1		**2**
Adolescents.	2			**2**
Treatment of illness.		1		**1**
Child and family care.	1			**1**
Selection/maintenance of IV lines/NG tubes.			1	**1**
Problem solving.		1		**1**
Observation.			1	**1**
Newborn to adolescent.	1			**1**
Substance abuse.	1			**1**
Psychologically disturbed child.	1			**1**
Children's death.	1			**1**
Children's ethical dilemmas.	1			**1**
Interpretation of BP/pulse etc.		1		**1**
Paediatric Trauma:				
PALS/Resuscitation	5	3	7	**15**
Critical situation/acutely ill child/adolescent	1	2	3	**6**
Injured child.			4	**4**
Practical trauma /simulations.	2			**2**
Ventilated child/adolescent.	1			**1**
Intra-osseous			1	**1**
Human skills infusion			1	**1**
Desired Knowledge:				
Child development/ milestones	3	3	4	**10**
Childhood disease/illness and conditions/effects of	1	2	1	**4**
Knowledge of special agencies/community	2			**2**
In-depth knowledge/increase knowledge of paediatrics	1		1	**2**
How children think and react/cognitive levels	1		1	**2**
Opportunity for outside speakers-police/child protection	2			**2**
Law and politics	2			**2**
Anatomy and physiology of children			2	**2**
Normal/abnormal child			1	**1**
Normal biochemistry of child/adolescent			1	**1**
Equipment (Cont.)			1	**1**

Desired Knowledge (contd.)	A	B	C	Total
Health promotion		1		**1**
A greater understanding		1		**1**
Other				
Practical management	1			**1**
Arranging outside speakers	1			**1**

Having indicated the skills and also some of the knowledge they would like to develop on an A and E course to care for children, they were then asked to indicate the characteristics of the course that they would prefer; for example its length, the assessment style and the type of qualification available. The respondents used their own words and phrases to describe those characteristics. Their responses are listed in the following table, (Table 7.23) and show a preference for courses that are shorter than six months. Work experience in the wards as well as in A and E would appear likely to be well received as would continuous assessment. A recognised qualification after completing the course had considerable support.

Table 7.23 Desired Characteristics of the Course

Characteristics of Course	No of Responses from each Unit.			Total
Length of Course	**A**	**B**	**C**	
Short: 1-2 week	1	4	1	**6**
2 -3 months	3		1	**4**
3 -6 months	6	3	5	**14**
6–9months		1		**1**
6–12 months			3	**3**
12–18 months		1	1	**2**
To meet all needs	1			**1**
Adjunct to RSCN		1		**1**
Type of Course				
Day release/ 1 day per week	2	2	1	**5**
Theory and practical		3	1	**4**
Part-time	1		2	**3**
APLS (PBLS)/ PALS style/input	1		2	**3**
Work-based /practical	2			**2**
Out of department		2		**2**
Full-time		2		**2**
Hands–on experience	1			**1**

Type of Course (Contd.)	A	B	C	Total
Group work in classroom	1			**1**
Modular		1		**1**
Experienced nurse course	1			**1**
Experiences to be included in the Course				
Ward based placements	3	1	2	**6**
Placements in children's A/E	2	1		**3**
Placements in nurseries/OPD/paramedics/psychiatry etc.	1	1		**2**
Placements with adolescents	1			**1**
Placements organised by self	1			**1**
Characteristics of Course.				
Assessment Process				
Continuous	1	4	5	**10**
Practical in A/E		1	6	**7**
Portfolio/journal	4		2	**6**
Essays / trauma and illness	3	1	1	**5**
Profile case study	3			**3**
Theoretical			3	**3**
Skills based /OSCE			2	**2**
Question and answer		1	1	**2**
Project		2		**2**
Reflective diary	1			**1**
Informal	1			**1**
Critical incident	1			**1**
Learning contract	1			**1**
Exam	1			**1**
Peer	1			**1**
Academic	1			**1**
Credits / Qualifications.				
ENB/recordable qualification	2	4	5	**11**
Credits/CATS	4	2	1	**7**
Part of Diploma/Degree pathway	3	3	2	**7**
Nationally recognised	3	1	1	**5**
RSCN in A/E		2		**2**
Specific to A/E	1			**1**
Progression to RSCN through APL/APEL		1		**1**
Certificate			1	**1**
Can be updated regularly			1	**1**
Other/ Comments				
No prolonged assessment			1	**1**
Medical model not nursing based.			1	**1**

Having identified the skills they would like to acquire (question 25) and the structure of the corresponding courses, (question 26) they were asked to indicate, by marking boxes, their preference for ways of accessing a course. The options that were presented to them are indicated by the column headings in Table 7.24. The numbers in the columns refer to the distribution of the 54 marked preferences from the 45 respondents.

Table 7.24: Preferred Attendance of a Course.

Responses from Unit	Full Time	Part-time Day	Part-time Half day	Distance Learning	Web-based Learning
A	4	9	2	2	1
B	6	4	0	1	1
C	7	9	3	3	2
Total	**17**	**22**	**5**	**6**	**4**

There was considerable support for both full time and part time day courses. It was interesting to note that distance learning combined with web-based learning attracted less than 20% of the preference.

The nurses were asked to identify the five most important things to be considered by a person designing an A and E course for the care of children. They were told that the course should be designed for nurses who are not children's nurses already. They responded in their own words. There were 197 responses in total; not all of the respondents listing five items. The type of responses are given in Table 7.25, together with the number of responses from each of the three Units.

Table 7.25 The most Important Considerations when designing a Course for nurses who care for Children in A and E.

Organisation and Type of Course	No of Responses from each Unit			Total No. of Responses
	A	B	C	
Relevant to Practice/department/benefits to patient care	5		4	**9**
Time/length of course	1		7	**8**
Venue/safety, security/accessibility			7	**7**
Correct level for experience	3	1	1	**5**
Recognition of existing/different skill and knowledge	3	1	1	**5**
Relevant lectures and visits	1		3	**4**
Relevant outcomes and content			3	**3**
Clinical Input/practice	2	1		**3**
Multi-disciplinary approach/ involve all staff/consultants	1		2	**3**
Distance/open leaning			2	**2**
Expert tutors working in practice			2	**2**
Short course		1		**1**
Modular			1	**1**
Flexibility to fit into work patterns	1			**1**
Theory and practice			1	**1**
Especially for new staff	1			**1**
Type of attendance			1	**1**
Specialist interest days	1			**1**
Fun		1		**1**
Interactive teaching		1		**1**
Volume of work reflect qualification	1			**1**
Reading materials			1	**1**
Evidenced based teaching			1	**1**
Placements				
Placement experience			5	**5**
Normal environment in community	2	2		**4**
Children's A/E	2	1	1	**4**
Children's unit		1	1	**2**
PICU	1			**1**
Qualifications				
Recognition/National qualification	2		5	**7**
Type of assessment	1		3	**4**
Limited written work	1			**1**
Fits into degree pathway			1	**1**

Qualifications (Contd.)	No of Responses from each Unit			Total No. of responses
Content of Course	**A**	**B**	**C**	
Normal developmental milestones/normal environment	6	3	4	**13**
Emphasis on care in A/E	3	4	5	**12**
Family-centered care needs	5	4		**9**
Play therapy and distraction techniques	3	3	1	**7**
PALS/Resuscitation	3	2	1	**6**
Communications	2	3		**5**
Social aspects of child safety/Child Protection	2	2	1	**5**
Anatomical differences	2	2	1	**5**
Drugs and medication	2	2	1	**5**
Differences in diseases/illness /ailments	1	3		**4**
Up to date and current health /important issues	1	2	1	**4**
Pain assessment/management	2	1		**3**
Differing needs of child and adolescent/holistic care	1	1	1	**3**
Good knowledge base of children's nursing/special needs	1	2		**3**
The Law and the child	1	1		**2**
Child major trauma	2			**2**
Welfare of child paramount/to come to no further harm		1		**1**
Advocacy and role of the nurse		1		**1**
Counseling		1		**1**
Awareness of referral agencies	1			**1**
Use of protocols in A/E		1		**1**
Other				
Cost	1	1	7	**9**
Teaching basics to reinforce children are nothing to be frightened of	1			**1**
Medical needs		1		**1**
Accept not everyone is an earth mother		1		**1**

Using the total number of responses as the indicator, the most important issues from this potential customer base for further training are the relevance of the course, its length and accessibility and its cost. The most important elements of the content of the course are recognition of the normal development of children, the special nature of caring within A and E and family-centred care.

The forty-five respondents to the completed questionnaire were also given the opportunity, after answering the twenty-eight questions, to make any further comments. They did not do so which perhaps reflects the size and detailed requirements of the questionnaire already.

7.5: Issues Arising from the Staff Survey

The response rate to the staff survey was only 31% and on the basis of this statistic alone the results cannot be generalised. However when the responses are supported by the participant observations described in the next chapter and the literature, then it is the view of the researcher that generalisability is feasible. The survey results give a clear view of the perception that A and E general nurses have about their ability to meet the holistic needs of traumatised children. Forty-one of the 45 respondents were experienced adult-trained nurses; only four respondents were below an E grade on the Whitley scale of seniority. The other four were children's nurses. This sample, in its proportions, of less than 9% being children's nurses, can be generalised to any district general hospital A and E unit because the literature confirms that adult qualified nurses make up the bulk of nurses who care for children. As there are 19 children's nurses employed in total in the Units surveyed it is surprising and disappointing that only four responded. It was expected that they would be keen to be involved in a survey that gives them an opportunity to advocate for the needs of children. A tentative and disconcerting conclusion is that they might have become socialised to a culture which assumes that children's trauma needs are being met and hence there is no need to be involved in this research.

The seniority of the respondents (defined by their position on the Whitley scale) is supported by their answers to separate questions about years of experience in A and E. Thirty five of them have more than five years and sixteen more than ten years of experience. They were also well

educated. Eleven had a degree. However, more interestingly, twenty-seven had obtained an A and E qualification compared with four who had obtained a children's nursing qualification.

Three of the 45 respondents are presently extending their skill to the level of Emergency Nurse Specialist Practitioner which is encouraging because of the recommendations by the government to significantly increase the number of these "consultant nurses". Two of these potential Consultant nurses are likely to be employed in A and E in two of the hospitals used in this survey but only one of the three is a qualified children's nurse. The other two, as ENPs, will be officially eligible to assess and prescribe treatment (including some drugs for children) as well as adults.

Almost all of the respondents to the survey recognised that children required special attention but only two recognised their needs at different stages of their development. Most of them considered themselves to be both confident and competent with both children and adolescents. Their confidence may reflect their competence to carry out defined medical tasks which are independent of the stage of development of their patient. For example, when asked what skills they possess to meet children's needs following trauma, only four nurses considered assessment of a child's development and only one identified the importance of including a child's weight in any assessment and the need for drug dosage based upon a child's weight.

The DoH (2000a) emphasised the need to prevent the tragedies of non-accidental injuries and needless child deaths and proposed adding training for all staff that are involved with children who might have been abused. Many local area child protection committees have produced policies for mandatory training but they are not being implemented by A and E staff. Yet only six respondents identified recognition of child abuse as a necessary skill, supporting literature

references to this lack of awareness (Fagan, 1998; Hall, 1995, and Powell, 1997). The implication, if the results of this research and the literature can be generalised, is that most of the nurses who care for children in A and E, unless in a specialised children's unit, might be failing to identify cases of child abuse.

The literature survey attempted to define knowledge and skill and also suggested that nurses did not understand the true meaning of these concepts. This was supported by the responses to this staff survey. The lack of ability of nurses to separate the words "knowledge", "skill" and "attitude" made it difficult on occasions for the researcher to categorise the answers to the questionnaire under those headings. Nevertheless the respondents to the questionnaire identified about twenty-five paediatric-nursing skills (Table 7.22) of which seven were specific to the traumatised child. They also identified a number of areas of necessary paediatric knowledge. Only one nurse identified the need for good interpersonal skills and two the need for listening. If they do not practice effective communication with children they will be unable to assess them adequately or stimulate them to play and hence benefit from that distraction to their condition.

If each of the 45 respondents had identified four paediatric skills (a modest expectation) the total number of times such skills would have been mentioned in the returns would have been 180. The actual total of 25 may mean that the majority of the respondents are unaware of the necessary paediatric skills in which case their confidence in nursing traumatised children is misplaced. It may be that this reflects that three staff nurses responded to the questionnaire for every two sisters. Alternatively perhaps, it may be that they were unable to recall all of the skills at the time they were completing the questionnaire. Observations in A and E (presented in the next chapter) will help to clarify their actual levels of paediatric skills.

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Chapter 8:

RESULTS OF PARTICIPANT OBSERVATIONS

This chapter presents the results of participant observation in three A and E units. The aim was to complement the findings of the staff survey and hence to determine the actual knowledge skills and attitudes of nurses who care for children following trauma. The observations were made in A and E Units in three distinctly different hospital environments. Those Units designated A, B and D, are fully described in Chapter 5. They are described more concisely in Table 8.1.

Table 8.1 Characteristics of A and E Units Observed

Unit	Type of Patient	Type of Unit	Type of Hospital
D	Children	Paediatric	Regional Children's Hospital
A	Children Only between 9.00 and 20.00	Paediatric, situated within an all ages Unit. Major trauma of children is cared for in Adult resuscitation	Regional Hospital Trust with a separate but attached Paediatric A and E Unit open part-time
B	All ages caring for children and adults in the same environment	General	General Hospital Trust

Unit A and B, the two Hospital Trust Units caring for all ages, were in the same NHS Region. This Region does not have a children's hospital. Hence Unit D was in a different NHS region. Observations commenced in Unit D because the children's hospital was considered likely to offer a quality benchmark for the care of children after trauma. A fourth Unit (designated C in chapter 5) was used in the other phases of this research but observations did not take place in Unit C because of its similarity to Unit B.

The observations started at four o-clock, having chosen this time because it is the start of the period when the majority of children are likely to suffer trauma. The first visit to all areas consisted of an introduction to the staff. It was considered important to function in the social group, be part of the team and be accepted as a qualified children's nurse; in essence following the recommendations of Miles and Huberman (1994), although they were referring to nursing research in general.

The researcher had prepared at the planning stage to be a participant nurse if occasions arose which would otherwise be detrimental to a patient. As the observations progressed in Unit A and B, the researcher became more involved "doing" as well as watching, listening and questioning. This happened because of a number of factors; very busy units on occasions, acceptance by the staff as a fellow professional, personal discomfort at only observing under these circumstances and confidence in my competency. Field notes were discreetly recorded in a small notebook. They were words and succinct phrases rather than lengthy sentences, to be used as memory prompts immediately after each observation period.

After each period, which was nominally four hours but longer if, for example, there was a road accident with children still being treated, I found a quiet corner in each hospital. There I reflected upon the observed skills, behaviour and interactions of the nurses and medical staff with the children and their parents. Using my field notes as a prompt these reflections were audio taped within a pre-planned framework; considering in turn the practices of assessing and then treating the children and then what those practices revealed about the culture of the Unit and its environment. Hence I left each of the three sessions at each Unit with all of my observations and impressions captured "live" with much rich but raw data. The tapes were

subsequently transcribed as hard copy and analysed to enable the data to be grouped and presented as a series of concepts and categories of observation.

Hurdles experienced during the observations included not being expected at a particular Unit on several occasions. Gaining entry into the social group of Unit B was more difficult than expected because of this. There was reluctance from some senior staff to accept my sudden appearance without notification or "warning" to themselves. On reflection this was perhaps understandable. Successful interaction with members of staff in all of the Units was very dependent upon the individuals on duty at the time. Skilled communication was essential to establish rapport and trust within all of the Units. Initially the researcher was probably restricted by what Leininger (1995) refers to as "front-stage knowledge"; information and observation being distorted by the group's protective facade. Relatively quickly however, the researcher believes she did gain the confidence and trust of staff, evidenced by body languages as well as the nature of the verbal communications. It is then reasonable to assume that "backstage information" which portrayed the real situation became evident: the realities of the group's knowledge, experience and behaviours.

Wilson (1985) noted that successful participant observational research requires researchers to go through channels of cultivating relationships, contouring their appearances, withholding evaluative judgements and being as unobtrusive and charming as possible. This process was followed but, none the less, it was uncomfortable to make adverse comments in the field notes. Reporting adverse practices created a sense of disloyalty; a feeling that this researcher had to come to terms with, as it is alien to her personality and honesty. It was also difficult not to become "too socialised" to the group, especially because the researcher sometimes chose to take coffee breaks with the team. The value of this was that some information appeared more

forthcoming during the informality of coffee breaks. However, it was recognised that it was necessary to keep distanced from the every day gossip and chitchat, which often included subjective or opinionated views, and to consider the ethical aspects in relation to the use of such information.

8.1 Categorisation of Results

The aim was to convert the large quantity of raw data, now in the form of transcribed audiotapes, into coherent groups or categories of observations that in turn would facilitate integration with the results of the other phases of the research methodologies: the literature survey, the Delphi exercise and the staff survey.

The approach was to examine the transcript line by line. The recorded observations and subsequent reflections were already roughly grouped under the four categories of assessment, treatment, culture and environment. The transcript had been printed double-spaced and with large margins, facilitating annotation of each observation about whether or not it was properly placed in its category. The first consequence of this exercise was to consider that all of the observations in their raw data descriptions could be put into one of the following four categories:

Table 8.2: Categories of Observation

Environment
Philosophy of care
Assessment
Treatment and Management of Care

Then it became clearer that the now-categorised raw data could be further sub-divided. After several iterations, subcategories were also developed. These are shown in Table 8.3.

Table 8.3 Categories and Subcategories of Observations

Categories	Subcategories
1. Environment	1.1 Units, staff and facilities 1.2 Surroundings for children 1.3 Number and types of patients 1.4 Activity and waiting times
2. Philosophy of Care	2.1 Organisation of patient care 2.2 Meeting child and parental needs 2.3 Family centred care 2.4 Play therapy and diversion
3. Assessment	3.1 Triage 3.2 Pain assessment 3.3 Emotional trauma and Gillick competence theory 3.4 Cultural implications
4. Treatment and Management of Care	4.1 Pain relief and drugs 4.2 Attitudes towards children and child protection 4.3 Staff roles

8.2 Presentation of Results

The results of the observations are presented for each of the three A and E Units in turn. The order in which observations are presented for each Unit is, wherever practical, the same as the order of the categories and sub-categories listed in the Table 8.3. On occasions the observations covered more than one sub-category at the same time. Unit D was observed first, then Unit B and finally Unit A. The results are presented in that order and particular issues are often illustrated by reference to observations of the care and treatment of individual children in specific circumstances.

8.2.1: Unit D.

This A and E Unit was situated within a Regional Children's Hospital. The entire hospital was newly adapted to meet the needs of children and was surrounded by child friendly facilities. It was fully staffed by qualified children's nurses and was managed by a paediatric nurse who was also a lecturer practitioner at the associated University. All of the equipment was specially adapted for children and of the latest technology, from electronic assessment to the computerised machines in individual bays in the resuscitation room which were used for monitoring highly dependent children.

An indication of the positive culture of child care was that the staff were contributing towards a "journal club"; in essence a source of published literature representing a great deal of information about children in A and E. This was available to all staff to support their practice and also to help those who are publishing articles.

The environment was appealing to children on entry, the evident immediate impression being friendliness and approachability. There were soft play areas at the entrance adjacent to the triage area. The main treatment area encircled a playroom with the station for the nurses and doctors adjacent to it. A bay of six trolley beds was alongside that station. Children who were immobile on trolleys and waiting for treatment played computerized games and watched TV. Examination rooms were used by the medical staff and gave privacy to the child or adolescent and their families. There were two resuscitation rooms, accessed separately from the main entrance which were used for children travelling to the Unit by ambulance who were usually highly dependent emergency patients. A teenage room contained a television and video and was appropriately decorated. Health education material was available and the room was

intended to be an area where adolescents who had social and psychological problems could feel that they had some privacy whilst their space was not invaded.

The entire department had children's pictures and collages on the walls, hanging displays on ceilings and attractive toys and equipment. This attempts to minimise fear and emotional pain whilst they were treated or waiting to be treated. It was attractive to children lying on trolley beds who could only look at the ceiling. Another playroom was available for children waiting for X-rays. A portable Sega machine was available to older children awaiting examination, X-rays or treatment.

Attached to Unit D was a general practitioner (GP) ambulatory unit. It had four beds within one treatment area plus four treatment rooms for suspected infected children and was managed by the Senior Nurse of the A and E department. It was staffed by qualified children's nurses and during my period of observation was still in its developmental stages. It was admitting children with minor emergency illnesses and proved to be an excellent way of alleviating the pressures from excessive GP referrals of both trauma and non-trauma patients. Children in this GP unit were assessed, observed and if possible sent home following treatment. Those who did not need to be admitted to a ward stayed in the Unit for up to 12 hours to be observed and undergo diagnostic tests. Children and their families were not constrained within the unit. They went to the park across the road during intervals of being observed for symptoms such as the development of rashes or the reduction in pyrexia or simply whilst waiting for test or laboratory results.

Unit D has treated over 100 children per day following trauma. During my observation sessions, an average of 50 children were treated each evening but major trauma, that was

children in need of high dependency or resuscitated care, was not witnessed. The staff considered these to be "quiet" sessions.

Waiting times for children was variable according to their need to see other medical consultants or because drugs needed to take effect, especially pain relief. If children received strong analgesia they were kept in the department for observation of any after effects. Wherever possible, waiting times were kept to a minimum and children were seen by specialist nurse practitioners. The typical stay for minor trauma was within one hour.

Child-related protocols and practice were available for many specific situations. These included drug, child protection, resuscitation and major incident policies. There was an abundance of guidance sheets for parents to care for children at home following injury. Their major accident protocol was regularly updated and had been put to the test in the weeks previous to my visit. A senior sister informed me that 170 children had been admitted with eye problems as a result of chlorine within a local swimming pool. The children were seen and treated in a matter of minutes rather than hours. This Unit normally only employs qualified children's nurses, but if a general nurse happens to be there, he or she can only give routine drugs after the amounts are checked and the application supervised by a children's nurse.

The needs of children and their parents were generally met during my observational periods in Unit D. Explanations of procedures to be undertaken, by both nursing and medical staff, were usually appropriate to the age of the child. In triage, due to the need for a speedy assessment, the emotional needs of children were not always addressed at that time. However they were dealt with subsequently by the primary nurse caring for the child. I am aware from experience that the urgency of trauma care does not always allow for complete attention to the emotional

needs of a child. Overall however, nursing and medical staff appropriately and sensitively applied the trauma treatments.

During my observations of the routine care of children following trauma there were no incidents that required a nurse to intervene as an advocate for the child. The senior sister did advise me that she educated the newly trained doctors, who arrived regularly in to the Unit, in the care of children. Because of this, independent advocacy by nurses was needed less often.

The quality of communication in Unit D was dependent upon the individual staff with no obvious correlation to their experience or qualification. I observed an infant with pyrexia accompanied by distressed parents. Whilst child and family friendly procedures were the overriding philosophy of the Unit there was still confusion between the parents and the children's nurse. A urine sample was required from this infant who was obviously not potty trained. Nevertheless the parents were given a potty and asked to obtain a sample from their infant. They were confused. They thought that the nurse must not understand that the child could not use the potty at her age. An explanation by the nurse that use of the potty was to avoid more invasive methods would have reassured the parents.

Information for parents was in abundance and attached to all treatment trolleys and other areas of the treatment rooms. They were colour coded according to the age of the child so that the appropriate after care instructions were given.

One senior nurse routinely called the parents "Mum" and "Dad", rather than by their names, which indicated to me a practice of routine rather than individualised care. The majority of the children responded well to the full explanations of their treatment by the

nurses and those that did not were cared for sensitively to help them come to terms with their injuries. I observed a child with a deep laceration; he had sliced the top of his thumb opening a tin. He was six years of age and quite distraught at the amount of blood and at the end of his thumb hanging by a flap. He was quickly consoled; good explanations being given which were conducive to his level of understanding. A junior children's nurse, cleaning a wound following a laceration to a nine-year-old boy, was sensitive in his approach. His communication skills were excellent and this assisted the boy to be distress free and obviously keen to be involved in what was happening.

The children who were frequent attendees appeared to mostly come from less fortunate backgrounds. It was obvious that these backgrounds did not influence the care they received or the attitudes displayed by staff. A family, who live on a gypsy camp and were from a well-known extended family of tinkers, brought in a one-week-old baby with breathing difficulties. The nurse complimented the family on the care of the infant. There were no negative comments made during assessment and treatment or afterwards after the family had left.

A large number of children were from ethnic minority groups, particularly Asian. Many of the mothers were unable to speak English and it was the older children and husbands who were the main communicators. Nevertheless, staff often included the mothers within the conversation, making them feel involved with the child. However, there were two occasions when Asian families were treated with less respect than that given to English speaking families. Communication to ethnic minority families, by one senior and experienced qualified children's nurse, was poor. I observed her assessment of children of Asian families on two occasions. They were treated with less respect than that given to obviously English families with a raising of her voice when the mother did not understand what was asked of her. On one

occasion, a mother had presented a concern that her baby boy was not well. Assessment revealed no pyrexia but showed signs of a chest infection. Mother was about to put on his woolly outer coat and leggings when this nurse asked her not to do so. It was probably not understood and mother continued to put the coat on the child. The nurse was very irritated, shouting 'please don't do that, it is too warm in here'. Another Asian child presented with an injury to his hand. There was an obvious lack of understanding by the child about what was requested of him during the assessment and no real effort to explain to the father. On this occasion, also there was a demonstration of irritation by this particular nurse.

Overall, communications between staff was excellent, especially between the nursing and medical staff. The medical staff were approachable and keen to discuss injury details with other staff. I witnessed young doctors communicating with children and families, in keeping with the philosophy of the department. One junior doctor was interpreting an X-ray image with a child, explaining how signs of swelling and tenderness of his right forearm indicated a fracture although it was not obvious from the X-ray. The child understood and accepted that it would still be treated as a fracture and that he would have to be referred to the fracture clinic.

The entire environment supports play to alleviate waiting or the stress of treatment. A play therapist is employed routinely in this Unit during the daytime hours. During observations into the twilight shift, there was no play therapist at that later time. Nevertheless, during all waiting periods it was obvious that children were occupied in a playroom or being supported by nurses with play and diversional therapy in individual treatment areas.

Unit D has a very child-friendly triage system, based upon the Manchester model: "Emergency Triage" (Manchester Triage Group 1997) which was designed by a team of qualified children's

A and E staff. This model was, in essence, a check list of all the different types of trauma related injuries ranging from those that need immediate attention to those that are less urgent for treatment. The urgency of care of each type of injury is listed. The algorithms are extremely rigid and all staff used them during the observation.

Children were also being assessed following referral by their GPs and prior to their transfer to the GP unit. These patients did put pressure on the system for the immediate assessment of injuries. Nevertheless and despite the extremely busy flow through of children, they were all seen and assessed very quickly and efficiently. Qualified children's nurses undertook all assessments.

All children were administered analgesic at triage if they were presenting with painful injuries, usually Calpol or paracetomol but stronger analgesic such as morphine and/ or Entonox (a mixture of nitrous oxide and oxygen inhaled via a face mask) for particularly painful trauma such as fractures and scalds. The assessment equipment was efficient; every child was weighed so that drugs could be calculated quickly. All children's nurses were able to give Entonox if they had been prepared via workshops run by the anaesthetic department. The Sister indicated that Entonox was often given to children with painful burns and scalds, and I witnessed that on several occasions. The pain was constantly monitored before and following the administration of analgesia to assess the effectiveness of the drugs. The child's pulse was monitored; the pulsometer attached to a finger also indicated the oxygen saturation levels. The temperature was read using an axillary electronic probe.

Two of the qualified children's nurses were undertaking a Specialist Nurse Practitioner course. I watched the Sister undertaking a case study as part of her practical training for that role. She

had assessed an injury correctly, administered an appropriate analgesia (morphine) and had referred the boy to X-ray. Then she diagnosed a fracture of the right wrist. She also detected that this particular indirect fracture needed to be surgically manipulated. Following consultation with the Registrar, who confirmed her diagnosis, I observed her apply a back slab (a plaster) by positioning the arm in a comfortable position until such times as he could be admitted to the ward for surgery later that day. This Sister has to complete 20 similar scenarios for her Specialist Nurse Practitioner assessment, supervised by senior medical practitioners. Whilst undertaking this training she is employed in a supernumerary status. Once she has completed the training she will be able to relieve doctors from minor injury involvement.

An application of the principle "Gillick competent" was witnessed when a twelve-year-old boy arrived from school with a suspected "Collies" fracture of his wrist. He was unaccompanied but the nurse, following an assessment of his emotional state and understanding, considered that he was sufficiently Gillick Competent to give consent for his own treatment in the initial absence of his parents. The Sister demonstrated a thorough understanding of the law relating to this scenario. She explained how on another occasion, it might be necessary to consider a fifteen-year-old incompetent by the Gillick principle to give his own consent.

I witnessed the treatment and also followed through a child with severe lacerations to his thumb. The child was given analgesia and antibiotics. The wound was not sutured but was steri-stripped with the bandage applied in such a way to minimise the pain the child was obviously experiencing. He also received diazepam (a sedative) and consequently had to stay in the Unit longer than might have been the case. The length of stay following sedatives and the balance of benefits to the child is a subject of current debate.

Child protection policies were available to all staff in Unit D. One situation that was observed was referred to social services. It was a child from hotel accommodation presenting with a chest scald. Bruising was noted underneath the child's chin and on her cheek. Although the suspicions were not discussed with the mother she was asked to return to the wound clinic with the child the following day as a way for the sister and doctor to further observe and assess the situation. In the meantime they consulted with social services and the health visitor to get their views regarding whether or not this child required further investigation and in particular whether or not she was already known to be at risk or on the child protection register.

Most children were followed up in medical clinics such as fracture as well as nurse dressing clinics. Those not given further appointments were referred to either a health visitor or GP. Referrals were also made to social services if there are any suspicions of child protection issues. All X-rays of children with suspected fractures are followed up in fracture clinic. As one doctor explained, fractures are sometimes difficult to identify in children and therefore no risk is taken if they are all treated as a fracture. If a child has been discharged on the understanding that bone injury is doubtful then they return to be seen by the medical consultant. All children and their parents are given follow-up guidance sheets relating specifically to their particular situation or injury. Telephone contact is assured if the parents have concerns following treatment.

The medical staff, although not all with paediatric qualifications or experience, demonstrated an awareness of children's needs and were obviously keen to expand their skills. The A and E medical consultants are all paediatric trained. Medical and nursing staff in Unit D were working well together as a team. Doctors sought advice from senior nurses and the senior

nurses were being supported by the senior medical staff to facilitate those nurses becoming trained specialist nurse practitioners.

Observation of practice in this specialist children's unit led this researcher to conclude that many of the children waiting to be seen by medical staff could have been cared for by ENPs assessing and managing minor injuries and hence reducing waiting times for both parents and children. Two emergency cases were observed, requiring intensive and specific medical care and delaying the treatment of many minor injuries. Nevertheless a positive benefit of this being a specialist children's unit was that, although busy with many children waiting to be seen by doctors, the children were kept distracted from their problems by involvement in play with the nurses.

8.2.2: Unit B.

Unit B is an A and E Department within a District General Hospital. It employs 2.5 full time equivalent qualified children's nurses, but the majority of staff are general nurses trained for adult care. The department is mainly suited to the care of adults although there is one paediatric room situated away from the main triage and treatment area. That room is decorated with brightly coloured nursery paper and contains toys and toiletries, including nappies. However it did not appear to be used on a regular basis and certainly not as a matter of routine during my time of observations. Most of the equipment in the main area was adult orientated and children were often in close proximity to adult patients. There were on many occasions frightening sights within the vicinity of the children waiting for treatment. There was not a system to ensure that children's nurses always cared for the children. One such children's nurse did express concern to me that the current system prevented her from working only with children because she was allocated to an area rather than by a caseload.

This is another busy unit with 13,453 children being seen in 1999. I specifically chose to work on November 5 because of bonfire night with the tendency for children to be injured whilst playing outdoors. This initial shift had 15 to 20 children presenting alongside adult patients during my four hours of observation. The majority of children presented with minor injuries, their ages ranging from seventeen months to seventeen years. During subsequent shifts the majority were teenage boys with sports injuries although there was one infant with pyrexia and a significant minority of small children with upper respiratory tract infections. The average number of children who came through Unit B each evening was between 20 and 25.

Children were often waiting several hours before being examined and treated. One example was a sixteen-month-old child who came in with obvious distress due to a possible chest infection. She had previously been diagnosed with congenital pulmonary stenosis (a heart condition) following birth. This infant was not within the definition of traumatised children who are the focus of this research but seeing her highlighted the need to prevent long waiting times and disjointed care. She had hyperpyrexia and was left in the paediatric cubicle for over one hour before being seen by a doctor. She appeared to be suffering from dehydration due to vomiting and lack of fluids over the previous 12 hours. Following assessment by a junior doctor, she waited a further half hour to see a paediatrician, then another half hour for an X ray and a further hour before being admitted into the paediatric ward as an inpatient. Both infant and parents were very distressed. No interaction with a nurse was observed. Thus I took the decision to become directly involved, monitoring the pyrexia and other issues such as dehydration and also supporting the parents.

Another notable delay was a three-year-old boy suffering from an asthmatic attack. He was placed in an adult treatment cubicle and left over two hours before being discharged with no treatment other than Calpol. The assessing nurse did not take his basic observations of temperature, pulse and respiration and he was left for a medical assessment. This delay appeared to be because the staff were busy and the child was uncooperative.

The surroundings of Unit B were mostly unsuitable for children. I observed a two-year-old child, with a finger injury and accompanied by both parents, waiting in a very small stark cubicle consisting of only a couch, chair and dressing trolley. There were not any toys or other suitable stimulation and the environment was unsuitable for an active child. The bored two-year-old climbed all over the furniture and trolley, challenging the parents and reinforcing their own stress. I gave him toys from the paediatric cubicle, to his and his parent's evident delight. This created some distraction for him during what was to become a long wait.

There did not appear to be an organised system of care for children and adolescents in Unit B. They were treated with the same priority as adults, although one nurse expressed that she did give children priority as a personal decision. Most children were placed in adult areas. I watched an 11-year-old boy in an operating theatre environment. This boy had a severe injury to his arm from a spiked railing. The environment was awe inspiring and frightening for both him and his father. He appeared very brave and keen to learn about the medical equipment but was obviously worried it might be needed for him. He expressed concern to me about being put to sleep and whether he might not wake up again. He was in this environment for about an hour and eventually and fortunately then received treatment from a doctor with an understanding of his fear. However, I did not observe any interaction with a nurse.

Children had to cope in the adult environment; the one paediatric room with its supply of nappies and toys was under-utilised. When I suggested a seventeen month old should be taken to this room because he needed a nappy change, this was agreed to be a "good idea". He was happy there, playing with the few toys that were about. A general trained nurse stated how she would have welcomed me to "be around last week" when a fourteen year old came in from a children's home and was undergoing an asthma attack. The teenager was apparently very frightened, reacted aggressively and was difficult to manage. This nurse informed me that, although she had undertaken a childcare course, it had not prepared her to work with difficult teenagers. I did however see some nurses demonstrating empathy with adolescents, but this was dependent upon the individual nurse. Care generally appeared to be routine. The ability to communicate with teenagers, particularly from the medical staff, was poor.

Family centred care was not evident during any of my observations in Unit B and a philosophy of care for children that included this concept did not appear to exist. During my observations of two girls of 11 years being cared for following a road traffic accident (RTA), the family were virtually ignored. The girls were kept immobile on trolleys for two to three hours without explanation and both parents and girls were frustrated and distressed by this. One of the mothers, who had been called in from work, was concerned because of her need to pick up a sibling from school and was offered no assistance in contacting friends. Food or drink was not available to any of the family.

The son of a male qualified nurse, employed in the same hospital, was treated very quickly and given priority over other children. Following negotiation between the nurse and the father (the qualified nurse) an agreement was made that he should give his son's treatment that included nebulised drugs and rectal analgesia. Whilst it may be argued that influence was an improper

factor and the father's skills were unusual, it does illustrate the benefits that can arise from involving a parent in discussion about the treatment of the child.

No play therapists were employed in Unit B and there was minimal play material. The latter, only available in the initial waiting area, appeared neglected and broken. Many children were bored. They were not routinely offered any distraction or toys. Routine assessment of a child's pain was not evident and there did not appear to be a specific policy for the pain relief of children.

Several staff commented to me that they did not like working with children. One male nurse had triaged a sixteen-month toddler and commented that he was unable to undertake the observations that were required. In this instance I did them for him. Another nurse who was assessing a three year old with known asthma and some wheeziness was unable to take his observations and left him to wait for more than an hour for the doctor. If he had communicated effectively with this little boy he would have found out that he had been visiting his Grandmother who had had surgery elsewhere in the hospital that day and also had an IV drip inserted. That image had distressed him because he thought he might also have to have an operation and this had exacerbated his asthma condition. On his treatment card I noted that it was written that observations had been unable to be taken because the child was uncooperative. He cried when anyone went near him but with my patience and "communication through play skills" I was able to undertake his temperature with a digital thermometer and eventually his pulse and respiration rates (that were both high). It was not too difficult for an experienced children's nurse. The measurements brought the doctor to him promptly. He was eventually discharged with no treatment other than Calpol and a recommendation that, if he deteriorated further, he should attend the hospital in the town

where he lived. On reflection a children's nurse could have assessed this child, had him seen by a doctor sooner and discharged within 20 minutes instead of waiting distressed for two hours. When he left the department at 8 pm he was tired and upset. It may be that these delays and accompanying stress had exacerbated his wheezy condition.

Staff attitudes and verbal and body language suggested to me that there was no discrimination when it came to caring for cultural minorities although there was an obvious irritation with a teenager who regularly visited the Unit under the influence of drink and drugs. However, it was this regularity of attendance rather than the nature of her problem that irritated staff. Her care was delayed and she was "goaded" on several occasions.

There did not appear to be a specific drug policy for addressing children's pain. Routine drugs (paracetomol or calpol) were given on occasions although I observed children and adolescents who would have benefited from stronger analgesia but were not offered it. I did not come across potential child abuse situations whilst in Unit B but was assured that a child protection policy existed.

There were several incidents when the child would have benefited from someone advocating on its behalf to relieve discomfort or pain. I observed an 11-year-old boy having an infected ear stud removed from a red and pus-laden ear lobe. Two doctors attempted to take out the stud, over a period of thirty minutes, before a senior doctor roughly pulled it out through the back of the ear. There was no explanation or any pain relief given. The result was a distressed boy and very unhappy parent. On another occasion a doctor criticised a child for being unable to swallow tablets, the child preferring an injection. A general nurse supported this child, explaining that this was a reasonable request and refusing to hide the tablet in jam as the

doctor had suggested. Neither a tablet nor an injection was prescribed but, following nurse persuasion, an elixir was eventually prescribed and given. One of the two eleven-year-old girls admitted following an RTA needed an anti-emetic drug for sickness, which created additional problems for her because she was told she was to receive an injection. No reassurance was given nor was there any discussion, or presumably any thought about any other mode of administration. A further and greater distress was evident whilst she continued to lie on the spinal board and in neck brace. She needed to go to the toilet and hence the use of a bed pan. At 11 years of age she displayed extreme embarrassment. The general nurse did not display any sensitivity to this situation and indeed displayed irritability; her only priority appeared to be to get the girl onto a bedpan quickly and without further injury. With Mum's assistance and my support (and the nurse leaving us) the girl managed to use the bedpan without further distress.

A 16-month-old infant, suffering pneumonia and a congenital heart condition, was left for over an hour with very distressed parents. This infant was an only child to parents who were in their late thirties and in their words "a very precious baby". No nurse attempted to talk with the parents who were left alone. At this point I felt a conflict between my professional responsibility to this child and the ethical dilemma of being an observer. However, recognising that the child was unwell and possibly suffering from dehydration, I decided to take a caring role. The parents were able to express their concerns to me which relieved them of some of their anxieties. The doctor was supportive but busy.

Care by medical staff in Unit B was very dependent upon the individual doctor. I witnessed doctors displaying a dislike to treat children and adolescents by rearranging the order of the triage cards to avoid having to care for them. They admitted this dislike, but would not explain it to me. One doctor was keen to ask me questions relating to children, as he was to have an

oral examination as part of his entry to Registrar status. He admitted to knowing very little about children and their specific needs. The paediatric SHO who visited the Unit on a number of observed occasions neglected to give immediate care to children including babies who were often left for long periods of time, up to 2 hours on one occasion.

8.2.3 Description of Unit A

Unit A is a relatively new children's A and E Unit within the general A and E department of a large hospital. It employs seven qualified children's nurses and consists of a self-contained area for relatively minor assessment and treatment with major paediatric injury care and resuscitation carried out alongside adults in a larger area for intensive care. The Unit is open to children and their families from 9am until 8pm and is open plan with trolley cubicles and three treatment rooms situated around the main area. A small play corner is situated in the main area and a number of offices and a toilet are adjacent. The offices are used by the paediatric health visitor and medical staff and also house the records and computer systems. Triage, where children are assessed and prioritised according to need, takes place at a desk situated at the entrance to the unit.

The surroundings are child-friendly with appropriate posters and hanging mobiles in most areas. The playroom attracts much attention and contains lots of large toys (washers, cookers, bicycles and a rocking horse) in addition to an area for manipulative and creative play with paints, crayons and modelling equipment. A television and video player is often available with appropriate videos to occupy children whilst waiting for their treatments and for their drugs to take effect. Adjacent to the play area is a rack of magazines for parents and comics for children as well as health education and accident prevention leaflets.

During my first two observations there were two qualified children's nurses on duty; one an A and E Sister (F grade) who had completed an RSCN course in the previous two years, the other nurse was normally employed on a ward but at that time was undertaking a nine-month rotational post in A and E. The Sister informed me of her intention to rotate between the adult and paediatric A and E unit so that she could constantly update her skills. With seven qualified children's nurses employed in total in this Unit, an attempt was being made to have specific care for children at most times. Nevertheless, it was obvious during my relatively brief observations that there was no system in place for ensuring that a children's nurse was always available to care for children in the resuscitation area.

During my third shift there were two nurses on duty until 5 o'clock and then one RSCN staff nurse supported by a nursery nurse/play therapist. It was obvious within a very short space of time that the RSCN was not coping with the numbers of children presenting. The department was too busy with the staff nurse beginning to panic and stating at one point "I have lost the plot". Later there was still the same RSCN plus an adult nurse (RGN) and a play therapist. There was also a student nurse, in the third year of a child branch course at a London university. A paediatric senior house officer (SHO) was always in attendance in Unit A in addition to an A and E medical officer.

The surroundings of Unit A were generally conducive to meeting the needs of children; the only difficulties encountered were for those who could not be accommodated in the self-contained paediatric unit due to overcrowding or due to the severity of their trauma. Under the latter circumstances they are referred to the adult cubicles or resuscitation rooms which were extremely frightening for both children and their parents because of their computerised equipment and medical machinery. A small corner of this resuscitation environment was

allocated for children, but without pictures or hanging mobiles or toys or child friendly medical equipment. I did not see this area being used.

21,000 children from newborn to 15 years old are seen in Unit A each year. On my first shift, a steady stream totalling approximately 50 children came though the department between 4 pm and 8 pm. What appeared to this observer to be a busy shift was, according to the staff, a quiet evening. This was supported by subsequent observations during which more than 50 children were seen and at times further admittance was stopped with the overspill being seen in the adult A and E department. Children also had to be admitted to the adult resuscitation area following for example, road traffic accidents. These were, according to staff, average sessions. This paediatric unit is obviously running to full capacity and is often insufficient in its provision of both staff and space. Many children had to wait many hours to be both seen and treated.

Policies specific to the care of children were not available to me at the time of my visits. There were however guidance sheets available to parents to facilitate the after care of their children. These included, for example, advice on bronchiolitis, immunisation and the care of injuries involving sprains, plaster of paris and fingers.

On entry to the paediatric A and E Unit, all of the records are scanned into a computerised system. X-rays can be viewed from a computerised screen although staff informed me that it is not totally reliable. There was no obvious child friendly philosophy of care operating in Unit A. Multi-professional record cards were used to document all information relating to the child's treatment but they were not specific for children. An RSCN F grade Sister said she was aiming to review the record cards because she felt that they did not reflect the children's needs.

Although there was space for child-relevant information they were mainly related to adults, including items such as pension details. Children were always admitted into the adult bays in the resuscitation area. The routine trauma care given there was good; nevertheless there was no evidence of the application of a child friendly philosophy involving emotional care. Although all the medical and trauma needs were met, there did not appear to be any paediatric philosophy or culture to address the holistic needs of the children and their parents.

Children's needs along with those of their parents, were met in the paediatric A and E unit to differing degrees depending upon the workload and individual staff present at the time. I observed a 10-year-old boy who had suffered a road traffic accident. On arrival in the resuscitation area he was irritable, with a possible head injury. I was surprised to see two paramedics, along with a Sister and an A and E medical consultant, trying to hold down the boy who was shouting for his mum in a very distressed state. Cannulisation was taking place in order that an intravenous (IV) line could be established. At this point a senior house officer (SHO) became involved. Later I found out she was employed by the paediatric intensive care unit (PICU) elsewhere in the hospital. They sedated the child before deciding to intubate. It was not apparent which nurse was in charge of his care but a G grade Sister and a relatively junior staff nurse were supporting the medical staff. I was somewhat surprised at the restraint procedures and observed him receiving sufficient drugs to "knock him out". The PICU team then arrived, a Sister and two anaesthetists who were obviously skilled with the medical care of intubating children.

During these procedures I was aware that there was a mother and a brother within the department asking whether they could see the child. The decision was delayed until he was fully intubated. The mother eventually came into the resuscitation room and was very distraught at the sight of the monitoring machines and intubation and by the IV lines that

were in both arms. The visiting SHO was able to support the mother. None of the nurses made any attempt to comfort that mother. This led me to believe that a philosophy of holistic (as distinct from medical) care of children in this environment was not established.

I spoke to the junior staff nurse, who was left with the care of the boy once he was stable and intubated. The doctor had asked her to "please relate with the parents and ensure that they were involved as much as possible" but she was unsure how to do so and did not demonstrate any initiative towards implementing this particular request. It appeared that she did not know how to deal with this situation, monitoring the child but ignoring the mother who was alongside. I saw the mother sitting with her head bowed, holding the child's hand and crying. I wanted to comfort the mother by touching and saying something to allow her to express her concerns. But I felt intrusive and unable to interfere with the situation. Later, once the child was quiet and stabilised, he was x-rayed and also had a CAT scan, revealing no further injuries. Then he was extubated, awoken and transferred to a ward for further observation and with only superficial lacerations.

Whether or not a nurse acted as an advocate for a child appeared to be dependent upon the individual staff. A small child suffering from Duchenne Syndrome (a type of muscular dystrophy) was seen in Unit A after a make-up eye crayon had been pushed into his ear. The doctor asked the nurse to irrigate his ear but this qualified children's nurse refused on the grounds that it was an unsafe procedure. The doctor, after taking advice from a senior medical consultant who stated it was acceptable, then undertook the procedure himself. The nurse informed me that she had refused with awareness of her need to work within her competence and for fear of the possibility of perforating the eardrum in such a small child.

I also observed a small baby having blood taken by a doctor without a nurse present who would normally advocate, on behalf of the baby, the use of local anaesthetic prior to venepuncture. Emla or Ametop was not applied and the baby was extremely distressed. This is a simple local anaesthetic procedure, relieving some of the distress for the infant and hence the mother. When I reflected at the end of my observations I noted that the doctor took it upon herself to take blood without seeking the view of the RSCN even though two paediatric nurses were working on the shift.

Communications with children and parents was generally good in Unit A in the minor injury areas but poor in the paediatric resuscitation room. I witnessed a student children's nurse undertaking a gluing procedure for the minor laceration of a 4-year-old boy. There was a supervising children's nurse. Both displayed good communication skills with excellent results for the child. In contrast, I observed the treatment following an RTA of a girl with facial and other possible injuries. She was conscious, warily and quietly watching all procedures. When her mother arrived, little attention was paid to her because the team were in "medical care overdrive" giving drugs and fluids through an IV line. This was a fearful sight for that mother. The staff carried on with their medical care, wiring the girl up to the machines, ensuring that she had a line for fluids and that she had pain relief. The medical treatment was very good. A staff nurse, looking after other adult patients, eventually came to talk to the child and to explain to Mum what was happening. There was no communication to the mother from the nurse undertaking the primary care and routine observations of her daughter.

Families were encouraged to be with their child in Unit A; the area specific to children with relatively minor injuries. They were usually kept informed of assessment and treatment. However, partnership in the child's care was less evident. Parents and the child were not

usually part of any decision-making regarding treatment. Information was however available to assist families with care after discharge.

A four-month-old baby had been vomiting coffee-stained blood and was brought in by her very distressed mother who was still breast-feeding; the father eventually joined them. The mother was also complaining of mastitis and had a consultation with the paediatric house officer who asked her to express some breast milk for analysis. No nurses were available to assist the mother. Hence I undertook the task. Had I not been available, the philosophy of supporting parents that undoubtedly exists in this Unit would not have been applied. Family-centred care was practiced less well in the resuscitation area. During treatment of a 10-year-old girl following an RTA, the parents were asked to go into the visitor's room in spite of the child constantly requesting her mother's presence. It was interesting to observe that a senior doctor appeared to get in a "flap" when the mother appeared. The radiographer, taking portable X-rays, also asked her to leave, but the mother was brought back again by a senior nurse who insisted that she stay, in the child's interest.

Play therapists are employed in Unit A to cover all opening times, that is between 9am and 8 pm. During my observations, I only met one due to the unplanned absence of the other. Children were fully occupied in play during waiting times. Sometimes children's nurses demonstrated play diversion tactics during treatment procedures. It was not obvious however that the play therapists themselves were fully involved in diversion therapy during distressing treatments. I observed a two-year-old who came with a laceration to the forehead which was glued. It was done in a very child-friendly way through play therapy and sticker badges to take home, overall an uneventful situation.

Triage is the initial assessment of the person coming into A and E and takes place once their basic details such as their name and address have been taken. There is no specific triage area for children in Unit A. Initial triage takes place in the larger general A and E Unit before referral to the paediatric Unit. On entry to the paediatric unit a nurse at a desk takes the child's card with its initial triage details and should then prioritise the treatment. A specific system of priority was not observed. During busy times, priority appeared to act on a "first come first served" basis.

Although no pain and treatment policy was evident in Unit A, many children with minor accidents needed pain relief. The paediatric nurse gave this routinely. Children receiving care in the resuscitation area also received appropriate pain relief, routinely and usually intravenously.

One qualified children's nurse, who was on a rotational secondment from the ward, weighed every child on entry to the Unit, stating to me that A and E doctors were not usually paediatric trained and did not necessarily recognise that weight was important to help decide drug dosage. She considered that pain relief was not routinely given to children in this Unit. An adult-qualified nurse, who had undertaken the specialist nurse practitioner course, was able to prescribe drugs such as paracetomol and antibiotics to children but she emphasised that, although she had been assessed as competent, she wasn't prepared to prescribe to any children under the age of 12 years. Other children's nurses in Unit A did not weigh children. An adult-qualified nurse asked me to check the amount of paracetomol to be given to a child. The doctor had prescribed the amount correctly, presumably on the basis of experience. The nurse had to draw the appropriate dosage in to a syringe from the stock of the drug; it being administered to children by syringe into the mouth. That stock had been supplied by the

pharmacy in liquid form in adult dosage amounts. When I questioned her she was still unsure she had calculated correctly and drawn the correct dosage. She had not, overdrawing by 25 millilitres. I concluded that there was a lack of management guidance in this Unit about adequate pain relief and the safe administration of drugs to children.

The children's nurses in Unit A were obviously aware of the emotional needs of children and their accompanying families, although addressing and meeting these needs was rarely seen, perhaps due to pressure of work. There did not appear to be any discrimination or neglect and hence inequality of the care with minority groups, cultural or ethnic.

Avoidance of children was not observed in Unit A and only members of staff in the resuscitation room exhibited an unsure attitude towards children. The children's nurses responded appropriately to child protection situations during my observations. On one occasion a children's nurse acted over zealously by questioning why a child was very subdued and didn't respond very much to communication. The same situation had not alerted any other staff. The children's nurse did not refer this child to the paediatric SHO but had demonstrated that she was aware of indicators and had made a conscious decision. A social problem was picked up quickly on another occasion and referred to the paediatric liaison health visitor. A 15-year-old came for treatment for a severe injury to the left eye following bullying at school. The children's nurse had identified bullying. It raised in my mind the question – which cannot be answered – whether or not an adult nurse would have acted similarly. I witnessed a 15-week-old baby, accompanied by a very anxious parent, with apparent pressure bruising to the palm of his hand. There was no explanation of how the baby had acquired these marks, but as no other marks presented it was thought not to be child protection issue with the child in any immediate danger. Nevertheless a qualified children's

nurse in conjunction with the paediatric SHO initiated the avenue of child protection and the outcome was referred to the paediatric liaison health visitor.

An infant was brought in by her grandfather who suspected the estranged father of abusing this child. His young daughter and her 18-month-old daughter were living with him and his wife. The infant was cared for by a childminder during the week but visited her father each weekend, who was known to be violent. The infant suffered from constipation and had been referred by the GP with "a cut on her bottom". The possible abuse wasn't investigated in A and E at the time as the child was distressed, but was referred to the paediatrician the following day. The children's nurse informed the paediatric SHO and me that the grandfather was a police officer working within the family child protection unit and that he may be overreacting to what might be an anal fissure due to constipation. This nurse had demonstrated knowledge and skill and hence competence in recognising that the child was not immediately in danger. Another child (3 years) was admitted with a sore vagina. After several consultations with the children's nurse and the doctor, this was referred to the paediatric liaison health visitor, for further investigation into the possibility of abuse. A children's nurse had again demonstrated awareness and a need to be vigilant.

Some of the qualified staff within the wider A and E department are involved in the Specialist Practitioner course. Advanced or specialist practitioners can undertake advanced triage and initiate X-ray investigations. They are able to manage minor injuries without the need for intervention from medical staff. If they have also completed the appropriate module of the same course, they are allowed to prescribe simple drugs from a defined list for both adults and children. On duty during one of my observations was such a specialist nurse practitioner.

However, she expressed her fears to me about her competence to take such an extended role with children.

The medical team in Unit A consist of both junior and senior trauma and paediatric medical staff. The medical consultants are not paediatric trained, although I met one who informed me of his interest in paediatrics. The junior trauma doctors and paediatric SHOs were seen to work well as a team in the paediatric unit. The trauma doctor attended to all trauma cases, with children suffering from illness or suspected abuse being referred to the paediatric medical officer.

8.3: Issues arising from the Results of the Observations

This chapter explained A and E children's nursing that was observed in three different hospitals, a Children's Hospital and two Hospital Trusts; the latter comprising of a District General Hospital (DGH) and a Regional Unit (RU). The RU had a Paediatric Unit. The DGH did not. It is apparent that the type of hospital influenced not only the physical environment of the A and E units, but their adult dominated philosophies and cultures. These appeared to reflect the organisational structure and hence operating practices. It is possible that the nurses observed in the DGH in this study might have performed differently in a more child-friendly environment. The observations were all made within a period of about four months and hence the longer-term influence of the environment of each Unit upon the competence of the individual nurse could not be assessed, but it is reasonable to assume that the environment had a significant effect on the observational data. It is reasonable speculation however that a lengthy period of working in the Children's Hospital Unit will continuously develop paediatric A and E nursing skills in staff who care for children alongside adults. The influence of culture upon the development of nursing skills via work-based training does not appear to have been researched.

The responses to the questionnaire about current knowledge, skills and attitudes, as well as the observations of current practices in A and E, have to be interpreted within a framework of understanding of the actual philosophies and culture within which these nurses are working.

In 1998 the Royal College of Nursing stated that a family focussed philosophy with corresponding protocols and procedures is essential for the best care of children in A and E. Such protocols and policies were available and usually being implemented during my periods of observation in the Children's Hospital. However they were not obviously available and the corresponding procedures were rarely being followed in the DGH and RU.

When observing children's nurses working in areas that also care for adults it was obvious that they did not care solely for children. This may be because the manager is failing to value their speciality. It might also be a reflection of the nurses themselves; that children's nurses did not want to lose their skills of caring for adults; that being at variance to Hutt (1983), who suggested that less than 30% of dual trained RSCNs found caring for adults attractive. The professional bodies emphasise that children's nurses should act as an advocate for the children and their families for their emotional as well as physical well being. They should also be a training support for non-RSCN staff. This was not often observed in practice, confirming the literature survey.

The initial step for all A and E nurses is triage, and Walsh and Kemp (2001) point out how cultural and social factors, including ethnicity, will affect the assessment of any patient. Many Asian and Afro-Caribbean presenting families were observed in all of the Units, and there were two nurses, in one Unit, from such backgrounds. However, in this study, the only ethnicity issue observed was the communication differences by one senior nurse in Unit D.

Dingwall and Murray (1983) stated that staff labelled patients and made decisions about them based on compliance or otherwise with their own notion of an "ideal patient". These observations (especially in Unit B) confirmed that children appeared to fall automatically into the category of rule breaker. Nurses who also cared for adults normally gave children priority although they were unaware of any triage protocols to do so.

The perception of competence in caring for children after trauma, which might have been concluded from the survey of nurses, was not validated by these observations. For example, inaccurate calculation of a dosage of paracetomol was observed. A drug error is more likely when nurses, trained to care for adults, do not have access to stock dosages for children. A potential overdose was avoided during the observations by the intervention of the researcher.

Children in the non-specialist Units were often not given adequate pain relief and sedation. This may have been because of training deficiencies but on reflection it may have been to avoid having to keep sedated children in hospital to monitor the effects of those stronger drugs. Dingwall and Murray (1983) suggested that staff might prioritise the care of children to discharge them as soon as possible.

In the Children's Hospital the A and E assessment was speedy and thorough with the need for pain relief assumed before prioritisation, with children weighed and dosages calculated. This skill may have been perfected by working within a culture focused upon children in contrast to the two other Units with their main focus on adults.

Communication was often seen to take place between parents and nurses in the DGH unit but not between the child and the nurses. This could reflect a lack of communicative skill with

children, alternately an ignorance on the part of the nurse of its importance. During the observations, play therapy was not observed as an alleviation and distraction therapy and only one play therapist was observed in Unit A. When on duty they were left to their own actions with the children.

Partnership in care was not evident in any of the Units during my observations, although nurses responding to the survey certainly considered it to be important. It could be argued that children are not in an A and E unit long enough to warrant a holistic care requirement and that the parents might themselves prioritise speedy medical action to alleviate the trauma of their child. As Lee (1999) points out, parental expectations in the A and E setting may be found to differ from that in the children's wards. The balance of responsibilities for care is perhaps different in the two settings, a subject perhaps worthy of further study.

A new initiative (DoH 2000b) for A and E includes funding for separate provision of care for children. Two of the A and E Units involved in this study have received such funding, including the DGH that was observed. Staff in that Unit are not confident that children will benefit, suggesting the planned discreet children's areas will not be viable unless there is an associated increase in qualified nurses to work in them. Upgrading the fabric and environment is insufficient.

In summary, when these observations are combined with the responses of the questionnaire, two statements can be made with reasonable confidence:

The qualified children's nurses working in the A and E Units and the Children's Hospital generally provide good quality care for traumatised children and their personal competence is likely to be increased by their experiences within that environment.

Nurses qualified to care for adults and also caring for children in A and E are usually not as competent as their self-confidence suggests and may not be benefiting positively in the context of becoming more competent whilst they work in General Hospitals. An obvious implication is that further education and training is required which should include practical placements where they would benefit from a period of secondment to a Children's Hospital if they expect to continue to care for children.

These two broad statements reinforce the implications for education and training providers made at the end of chapter 7 with particular emphasis upon the need to experience the culture and practices of the paediatric A and E environment for nurses who present themselves for further training. This observational study has made apparent the significant differences between the experiences of work based training in a Children's Hospital and District General Hospitals These variations in individual experiences should ideally be taken into account in CPD curricula for those individuals.

Chapter 9:

KEY OUTCOMES, RECOMMENDATIONS FOR FURTHER EDUCATION; FURTHER STUDY AND SUMMARY

The overall aim of this study is to facilitate improvements to the training of paediatric nurses and also to the practice of caring for traumatised children in A and E.

The research tools used have been supported by a literature review. The first tool was to use a Delphi panel of qualified and experienced children's nurses to identify the essential knowledge skill and attitude of a competent nurse. The attributes actually displayed were deduced by the other two research tools; a questionnaire survey of a range of qualified nurses working in A and E and observation of their practice.

This chapter synthesises the results presented in earlier chapters and the issues that have already been discussed in association with those results. This makes it possible to make a number of statements that can be considered to be key outcomes from this research. Recommendations are then made for further study. This chapter finishes with a summary of all that has been done and achieved.

9.1 Key Outcomes of the Study

The key outcomes from the study, expressed in concise terms, are given in Table 9.1. The first four relate to the practice of nursing and lead to the last three which relate to the training of paediatric nurses. This chapter consists of comments or recommendations to improve the education and training of nurses who care for children after trauma and which should also improve the corresponding nursing practices. These comments and recommendations satisfy the overall aims of this study.

Table 9.1 Key Outcomes of the Study

1. The care needs of traumatised children are different to those of adults
2. The majority of traumatised children may not be cared for by nurses with the necessary competence in the Units studied.
3. The majority of traumatised children do not appear to be cared for in an appropriate environment.
4. Children need holistic care.
5. Adult-trained nurses perceptions of their own competence are probably different from the actuality.
6. It is recommended that nurses should be trained in both paediatric and A and E nursing skills to meet the needs of traumatised children.
7. Personalised and flexible education and training is recommended to produce competent children's A and E nurses.

Each of these outcomes will now be discussed in terms of further educational needs and in turn drawing together the three phases of the research and the literature research.

9.1.1 Children's Needs are Different

The care needs of traumatised children are different from those of adults. The literature, the Delphi panel and the staff survey confirm this. The literature survey underlined that children have different reactions to trauma from those of adults (DoH, 1991a; RCN, 1998b; Walsh and Kent, 2001). Price (1994) discusses the differing needs of children from those of adults and maintains that underpinning knowledge is a pre-requisite to meeting the needs of children in hospital. This was supported by the Delphi panel who identified the specific paediatric knowledge, skills and attitudes that must be developed for their nursing care. The staff survey indicated that the majority of A and E nurses have a lack of underpinning knowledge of the care of children. This is supported by Burgin (1995), Smith (1997) RCN (1998b).

Observed practice is that trained general nurses have limited recognition of the necessary knowledge to care for children, probably due to omission in their training and hence are constrained in their ability to provide the corresponding quality care.

The Government has raised attention to the rights and different needs of children in hospital (Children's Charter, DoH 1996). The RCN (1999a) pointed out that children's nurses should act as advocates for children and their families and that they are also needed to be facilitators and support for non-RSCN staff; underlying again that the needs of children are different. The English National Board (ENB, 1985) outlines requirements and validates individual HE children's nursing education programmes and emphasises the need to relate care to the developmental stages of each child and to the social and cultural influences on both the child and its family. The individual education providers determine the detailed content of their own curricula.

The knowledge and skills that enable carers to meet the needs of children are in general different from those for adults. For example Robertson (1995b) highlighted the need for nurses to have specific skills to care for children in addition to the generic abilities required for entry into the nursing profession. The premise that care of children is a specific and necessary skill is supported by the 1991 DoH Standard which states that two qualified children's nurses should be on duty 24 hours a day in all children's wards and departments. The Audit Commission (1993) also underlined differences; they emphasised that nursing children requires skills of observation and psychological support which are different from those for nursing adults.

9.1.2 The Majority of Traumatised Children are not Cared for by Nurses with the Necessary Competence.

This study had adapted Benner's Model of the levels of nursing competence (see Table 2.3, page 23) and has shown that an adult trained nurse who can be considered an A and E nurse in the context of caring for adults can be incompetent when caring for children. The literature , survey and observations revealed that trained adult nurses care for the majority of children in A and E. Children have different needs and the lack of effective communication skills to address their emotional care was lacking on many occasions during the observations. Partridge (2001) reports how the fear of caring for children often leads them to be overlooked. This was supported by the staff survey and the participant observations within this study, especially in the areas where children were cared for alongside adults. Hence it is reasonable to assume that the majority of traumatised children are not cared for by nurses with the necessary competence.

9.1.3 The Majority of Traumatised Children are not Cared for in an Appropriate Environment and Culture.

The literature review made it very clear that hospital environments in general and the A and E environment in particular can be frightening for a child. The physical environment can be daunting; large, noisy, austere and often violent with mysterious equipment, people in uniforms and patients on trolleys or waiting anxiously in clinics. Furthermore, physical resources are not the only environmental contribution to the welfare of the child in A and E. The atmosphere, as perceived by the child, will depend upon the attitudes of the staff as well as their knowledge and skills. Staff attitudes are in turn influenced by the culture of the Units within which they operate; for example whether or not it encourages the emotional welfare of the children.

Elliott (1999) maintained that the adequate assessment of children depends upon the environment and culture of the A and E department. Children have needs that require assessment and care in a systematic planned approach (see the working philosophy on page 13). Underpinning knowledge about the needs of children is as essential to a systematic assessment as the culture and philosophy of the A and E, this was demonstrated in the children's hospital but lacking in the Units where children were cared for alongside adults. The data from the A and E nurses in the staff survey gave some recognition that children require a different philosophy of care but the observations of practice suggested this was not considered to be a priority in practice in the DGHs. This supports Partridge (2001) who found that nurses demonstrated apathy towards the development of similar philosophies of care for children in another DGH unit.

Qualified children's nurses are equipped with an appropriate framework of operating principles and associated attitudes in addition to the skills and knowledge necessary for the care of children. However, these nurses are in the minority in most A and E Units and observations during this study reveal that they frequently do not practice this framework and philosophy in general hospitals. The failure to practice is a failure to operate fully with the culture and framework defined by, for example, Bentley (1995).

9.1.4 Children Need Holistic Care

Since the philosophy of care for children in A and E is important (RCN 1998b)(see page 13) then their individuality and the need for emotional support for them and their family is essential. There is considerable evidence in the literature about the conflict between the need for the medical treatment of the trauma, the emotional needs of the children and their families

and the ideal of a holistic approach to their treatment. For example Lee (1999a,b) advocates partnership as the underpinning philosophy when caring for children in any setting including A and E, but acknowledges that such a philosophy may not be familiar to the majority of staff. Resistance can be expected, but that should not be allowed to prevent implementation of that partnership when both the child and its family would benefit. Lee believes it is important to recognise that the family perceptions of the problems of the child may differ from those of the nurse. Only after open discussion between family and nurse can acceptable proposals and agreement be made. Valentine (1998) found that senior nurses had a more positive attitude than juniors towards parental empowerment. This has implications for the development of those junior nurses; they need supervision and support from their senior colleagues who are good role models. Whilst the data from the staff survey indicated that some nurses considered family centered care to be important, many junior nurses observed in Units A and B lacked the necessary communication skills considered to be important for the implementation of parental empowerment. In essence, this is a requirement for work-based training and should be a component of the continuous professional development (CPD) of the junior nurses. If such CPD is to be effective and child and parental empowerment is to become a reality, then it must be one of the underpinning philosophies for all paediatric A and E units.

Participant observations, as part of this study, confirmed the literature that the quality of care of traumatised children is enhanced if their emotional needs and fears are dealt with as well as their physical damage. The fact that they appeared largely not to be met in A and E Units in general hospitals is a cause for concern, about which recommendations will be made later in this chapter.

9.1.5 Adult-trained Nurses' Perceptions of their Own Competence are Different from the Actuality.

The reason why there are differences between perceived and actual levels of competence can be understood by taking the model of five levels of nursing competence proposed by Benner (1984 (as outlined in Chapter 2 page 23) and adapting that model to apply to nurses who care for children in A and E. The result is shown in Table 9.2.

Table 9.2 Model of Nursing Skill when Caring for Children in A and E Units

Expert	Expert Children's Nurse				
Proficient	▪ Nurse with RSCN or RN (Child) qualification ▪ A and E qualification	Proficient Children's Nurse			
Competent	▪ Specialist Nurse Practitioner and nurse prescribing education	▪ Nurse with RSCN or RN (Child) qualification ▪ A and E qualification	Competent Children's Nurse	Adult Nurse with experience and having undertaken an extended child care course	
Advanced Beginner	▪ Experience		▪ Nurse with RSCN or RN (Child) qualification	Adult nurse undertaken a short child care training	
Novice					Adult nurse with little experience and not having any child care training

An adult trained-trained nurse, if she has not also had training in childcare, will only have the expertise of a novice in the context of caring for children in A and E. This is contrary to the perceptions that such nurses have of themselves, as illustrated by their responses to the staff survey. They are assuming competence based upon considerable A and E experience, although in Units which do not clearly distinguish between the care needs of children and adults.

The adult trained nurse can gain expertise by additional training, from "advanced beginner" to "competent" in the context of caring for children in A and E by undertaking one or more appropriate short courses. The expertise they achieve will depend upon their individual knowledge and skills at the outset as well as upon the quality of the courses they follow. But they might not achieve "proficient status" unless they undertake significant specialised training such as that leading to the RSCN or RN (Child) qualification. Even an RSCN may be considered "expert" without considerable relevant work-based training and experience and a positive attitude towards life long learning.

Casey (2000) points out that professional competence encompasses both motor and cognitive skills; with the need to perform clinical actions as well as to make clinical judgements and decisions, and manage information, knowledge and evidence. There is evidence in this study that children's nurses are more competent to meet the holistic needs of their clients and are more able to make clinical decisions and manage information appropriate to their development to autonomous and specialist practitioners, that is, capable of working independently of medical staff in dealing with minor injuries. Many senior adult trained nurses in this study had considerable experience of working with children in a DGH A and E units and considered themselves both competent (even proficient) and confident in that care. What was revealing in this study was the suggestion, derived from the observations, that the actuality was different. Informal benchmarking the performance of such nurses against their

RSCN colleagues in Children's Units, during the observations in Children's A and E Units underlined their relative lack of competence. However, it is probably unreasonable to compare the performance of these nurses with those RSCNs working in A and E in children's hospitals. Environment and culture may influence their performance, and therefore a more appropriate comparison would be with RSCNs working in another DGH with child-focused management and practices. Despite this, the staff survey and observations did reveal their lack of knowledge and understanding of children's needs, particularly the need to relate to the stage of development of the child from both a physical and emotional viewpoint. Specific examples observed were incompetence in calculating and administering drugs to children and poor communication methods. Hence nurses did not appreciate that they had a limited ability to provide a more holistic quality care. This causes a particular difficulty in terms of staff recognising that they indeed have a training need and therefore they may have a negative attitude to further education and training.

9.1.6 Nurses Should be Trained in Both Paediatric and A and E Nursing to Meet the Needs of Traumatised Children.

The specific skills needed for the general care of children in A and E have been identified and presented in checklist format as the results of the Delphi exercise (Chapter 6.). Those data make it clear that traumatised children need to be cared for by nurses who have an appropriate balance of paediatric nursing and A and E nursing skills. The Benner model of nursing competence, described in chapter 2, and applied to A and E nurses in Table 9.2 has been further adapted in Table 9.3 to show that to be proficient or expert as distinct from merely competent, as the nurse of a traumatised child, it is necessary to have both a paediatric and an A and E qualification. For completeness the skill levels of adult-trained nurses in the context of caring for adults is also shown.

Table 9.3 **Adaptation of the Benner (1983) model, demonstrating that paediatric and A and E nursing qualifications are needed to be proficient to care for traumatised children.**

Adult Client	Level of Nurse Skill	Child and Family
.	**Novice** ▪ No experience of the situation in which they are expected to perform ▪ Taught about measurable parameters of patients ▪ Rules to guide actions ▪ Following rules is against successful performance as can't direct most relevant tasks to perform in actual situations	Adult trained nurse with no experience with children.
	Advanced Beginner ▪ Demonstrates marginally acceptable performance ▪ Aspects are in contrast to measurable parameters but identified through prior experience ▪ Follow instructions and guidelines ▪ Need help in setting priorities as still function on general guidelines ▪ Need preceptors.	Adult trained nurse with little experience with children.
D grade Adult trained nurse	**Competent** ▪ Nurse can see his or her actions in terms of long-range goals or plans of which the nurse is consciously aware. ▪ Lacks speed and flexibility of proficiency but has a feeling of mastery and ability to cope. ▪ Achieve efficiency in organisation	Adult trained nurse with much experience and some education with children. Qualified children's nurse without an A and E qualification
F and E Adult trained nurses With A and E Qualification	**Proficient** ▪ Perceives situations as wholes and perceives the meaning in long-term goals. ▪ Can recognise when the expected normal picture does not materialise ▪ Improves nurses decision making ▪ Identifies the important aspects and attributes ▪ Considers fewer options and hones in on an accurate region of the problem ▪ Requires a deep understanding of the situation before maxim used.	Qualified Children's Nurse With an A and E qualification
Nurse Practitioner G grade Adult trained with A and E qualification and Specialist nurse practitioner qualification	**Expert** ▪ Expert decisions are holistic ▪ Nurse does not rely on guidance or rules top connect understanding of the situation ▪ Enormous background of experience with intuitive grasp ▪ Deep understanding of the total situation ▪ Perceptual acuity and recognitional ability.	Qualified Children's Nurse With an A and E qualification and Specialist practitioner qualification

9.1.7 Personalised And Flexible Education And Training Is Needed To Produce Competent Children's A And E Nurses.

Table 9.2 makes it clear that an adult-trained nurse, very expert at caring for adults, can have novice level skills when it comes to caring for traumatised children. Similarly an experienced qualified children's nurse who has only cared for children in a ward environment would also be a novice when first working in A and E with a major trauma case load. These two types of nurses have very different personal development needs to acquire similar levels of competence in caring for children in A and E. They are perhaps extremes but serve to illustrate the need for personalised training programmes.

The content of the training programme is not the only feature of the programme that should be "tailor made". Nurses want courses which minimise disruption to their life styles including work as well as enhancing job satisfaction and careers. Attention needs to be given to the length of courses and the times at which they are available to continue to encourage continuous professional development (CPD) and life long learning.

9.2 Recommendations

This study has identified discrepancies between the required and actual competence of many of the nurses who care for traumatised children in A and E. Relatively straight recommendations will now be made about how to close the knowledge and skill gaps that contribute to those competence discrepancies. Recommendations are also made relating to the attitudes of nurses and to nursing practices. These are more complex because attitudes are influenced by the total work and life experiences of nurses and not just by their previous education and training. These recommendations complete the aims of this study; to recommend improvements to the educational processes which might better develop the skills for nurses caring for children, and

to the practices of caring for traumatised children in A and E.

The recommendations are directed to three different categories of people: to education and training providers, to the nurses themselves and finally to health care policy makers and managers including the managers of A and E Units.

9.2.1 Recommendations to Education and Training Providers

Table 7.20 in Chapter 7 lists the specific knowledge and skills that practising A and E nurses, mostly adult-trained, consider important to be able to care for children. The number of nurses who identified each attribute probably indicates the level of awareness of this sample population, although it may also reflect a lack of ability to remember attributes at the time of completion of the questionnaire. The nurses who contributed to table 7.20 had one thing in common; they cared for adults as well as children in A and E. None of them were expert nurses, as defined by the Table 9.3 adaptation of the Benner competence model. Education and Training providers are recommended to compare the Table 6.16 list from the Delphi panel with the table 7.20 and then with their current curricula. The items on that list which are mentioned by the "non-expert" nurses, should be given particular attention.

Table 6.16 in Chapter 6 (page 100) shows the categories and sub categories of required knowledge and skills to be a competent children's nurse, as determined by a Delphi panel of experts. Table 7.19 in Chapter 7 lists the knowledge and skills that practising A and E nurses could think of and may actually have. It was derived from a questionnaire to a sample of nurses with a range of qualifications but mostly trained to care for adults. They all had one feature in common however; working in A and E units which cared for both adults and children. The list gives the specific knowledge and skills that stated members of nurses

recognised as important, and presumably currently use, for the care of children. At least therefore, it reflects the degree of awareness of these attributes. The observations in A and E showed that many nurses do not apply even the attributes, despite there being fewer than the list considered essential by the Delphi panel of experts. Current curricula should be compared with these checklists, to identify gaps and areas which require further emphasis.

Particular attention should also be given to the balance between developing the paediatric knowledge and skills for the general care of unwell children and those specific to post-trauma care. This balance should reflect the staffing needs in the region covered by the education provider; balance between the numbers of qualified children's nurses that are needed in the wards or community in that region, compared with the number that are needed in A and E units.

Attention should also be given to the balance between medical knowledge and skills and those of emotional care, communications, diversion therapies, child protection issues and negotiated family centred care.

This study suggests that the majority of A and E nurses prefer part time courses of up to six months long to develop their competence to care for children. However, this may be in conflict with managers coping with limited resources and finding it difficult to release staff. It is recommended that course provision should be much more flexible, with modular courses with credits for each module, and a mix of core and optional units. This is in line with current HE systems. The latter should include advanced A and E training for those children's nurses who have corresponding career aspirations. Another advantage of modularisation is that stand-alone units can be offered, (as they often already are) to any health care profcssionals, not just nurses, who want to enhance their knowledge and understanding. All modules should be

offered at times of the day and week to reflect the customer's needs i.e. the needs of nurses and their managers. Customer needs rather than the convenience of the educational establishments should always be the priority, as is the case in many areas. In practice it has to be recognised that present University funding via the commissioning authorities makes it difficult to meet all of the staff development requirements of individual NHS Trusts. In addition there are often further problems such as the lack of clinical placements, classroom facilities and appropriate University staff. However, wherever possible, the criteria adopted by the Universities should be the same as if they were operating in the private sector; organising their courses to ensure customer satisfaction over quality, price and delivery.

Nurses also want recognition of their time investment in further education and training by gaining qualifications or awards that are recognised within the national framework. This is another opportunity for education and training providers to be imaginative and innovative; in essence to modularise the qualification as well as the course. The principle of credits for modules towards a final qualification is well established. Some of the modules towards a children's nurse qualification; for example for advanced A and E skills or Child Development or Child Protection, should have their own awards. They should be accredited by for example, the new National Nursing and Midwifery Council (NHSE 2000) (Post ENB and UKCC) or the Qualification and Curriculum Authority as well as by the Occupational Framework for Health.

9.2.2 Recommendations To Nurses Who Care For Children in A and E.

Children in A and E are cared for by both adult and child trained nurses and there are two categories of the latter; those who qualified as children's nurses early in their careers and whose career history has been largely or entirely with children, and those who trained to care for

children much later, after significant experience in general nursing.

In an ideal world, adult trained nurses would not be the primary care nurses for children and the recommendations made to managers in 9.2.3 reflect that view. This study has shown that general nurses, even if highly experienced and of specialist nurse practitioner status, are not proficient in caring for children. Indeed unless they have some childcare training, they can be classed as novices when carrying out that role (Table 9.3 in this chapter). It is recommended that nurses trained to care for adults, even those who can be classed as expert in the context of the care of adults, seek the advice of their child-trained colleagues when caring for children. Managers should ensure that systems and practices in their Units facilitate these mentoring processes, and all involved will need to recognise the possible sensitivity of a relatively junior children's nurse advising a senior adult-trained nurse.

Nurses who obtain RSCN or similar qualifications early in their careers and who work in A and E in a general hospital should endeavour to retain a positive attitude towards holistic care, even when the environment in which they work is unsupportive. All qualified children's nurses should be encouraged to facilitate environmental change towards holistic care. The opportunity to succeed and hence the responsibility for making that happen is likely to rest with the most senior nurses and these may well be those who gained children's nursing qualifications later in their career. They will also need to influence the managers to do this.

9.2.3 Recommendations to Managers

The medical model of care dominates in A and E in general hospitals. This research has shown that those who employ qualified children's nurses do not always take full advantage of their specific knowledge and skills. Unit managers in these General Hospitals are recommended to

consider benchmarking the quality of care they give to children, against the care not only given in the A and E unit of a children's hospital, but also with those District General Hospitals who successfully meet the needs of children in A and E. Not all of the practices and procedures of a children's hospital can be reproduced in a general hospital because of the needs of the latter to care for adults as well as children. But large numbers of children do present in A and E in a general hospital. Consideration should be given to having a Senior Paediatric Nurse who is accountable within that Unit for the quality of care of children. He or she should have the authority to assign children's nurses to look after children, perhaps within a framework where only if they have spare time would they care for adults. Partridge (2001) maintains that the concentrated use of such children's nurses would allow them to regularly use and maintain their clinical skills with children.

Unit A in this study was the "half way house" between a Unit in a children's hospital, focused only on children and a Unit in a general hospital focused on adults but caring for both children and adults. Unit A has areas reserved for children although major trauma facilities have to be shared. The idea is effective if, as in this particular case, there is not a children's hospital in the region. However a number of shortcomings in practice have been identified in this study. Managers of these types of Units are likely to obtain early benefits by benchmarking their practices against those of a children's hospital because they already have some of the child–friendly and hence child focused facilities in place.

University-based education and training providers cannot, by their very nature, "deliver" a fully competent A and E children's nurse. Competence can only be fully developed in the workplace. For this to happen, nurses and their line managers and the Unit manager must have a positive attitude to continuous professional development (CPD). However there is

evidence from this study that the specific knowledge and skills of qualified children's nurses is not fully recognised and utilised (Watson, 2000) in A and E in general hospitals. These can be a disincentive to CPD. Unit managers should consider this factor and also whether or not they have an appropriate balance between medical, holistic and family-centred care for children. Part of the reason for the impression that children's nurses are undervalued is the dominance of the medical model in general hospitals and the lack of support for, and hence opportunity to practice, holistic care which is a significant part of the training of an RSCN. A further support for the concept of being under-valued is the perception that the career progression for an RSCN is likely to be more rapid on the wards than in A and E.

To remedy the shortage of skilled children's nurses and to meet the guidelines of clinical governance it is important, via a blame free culture, for staff to identify where the performance of themselves and their colleagues could be improved, and take positive steps towards improving clinical effectiveness. The three main functions of clinical effectiveness are being to monitor, to inform and then to change (NHSE 1996). Once an enabling culture is achieved, staff need to be encouraged to develop through continuing professional development (CPD). Children and parents put their trust in health care professionals and need to be assured that they receive care and treatment from appropriately trained staff. CPD should no longer be a luxury. For this reason the UKCC replacement body, the Nursing and Midwifery Council NHS Executive 2000, must enforce the Post Registration Education and Practice (PREP) requirements, (as discussed in Chapter 2) by improving their present requirements and audit procedures for the re-registration of nurses (which happens every three years). Trained children's nurses cannot re-register to work with adults but the reverse is accepted. This is an anomaly in the system. The PREP requirement for re-registration needs to be CPD specific to

the needs of the client group and also needs to be more readily enforced as recommended in the PREP document.

The Consultation document "*Modernising Regulation – The New Nursing and Midwifery Council* (2000)" is proposing a Council made up of equal numbers of nurses, midwives and health visitors, but makes no reference to professionals trained specifically to meet the needs of children. This suggests that the national nursing and government bodies do not recognise the fundamental differences between children and adults in the context of care. If this is so, it is hard to see how the regulating bodies are going to ensure that children are being cared for by nurses specifically skilled in their care. Thus it is recommended that there should be representation on this important nurse and midwifery regulating Council for experienced children's nurses.

The present validating bodies (UKCC and ENB) have recognised the need for short track education of general nurses who care for children in high dependency Units: both paediatric intensive care Units and general intensive treatment Units. This came about because of high profile cases of children travelling considerable distances and dying in ambulances before reaching high dependency units away from their own locations. There is a shortage of qualified children's nurses for such Units together with a shortage of the high dependency beds themselves. This led the government to recommend suitable fast track routes for general nurses to convert to children's nurses whilst also being trained in the skills of high dependency nursing. There is a corresponding need for managers to support A and E general nurses to acquire the necessary knowledge, skills and attitudes to care for children.

Fast track education to cater for those who wish to care for children is only a short-term solution. In the long term the initial education of children's nurses should revert to pre-registration for a Diploma or Degree via Child Branch programmes. This researcher recommends a choice of three models of continuing education for such programmes. These all involve the modular provision mentioned earlier in this chapter, allowing exemption by taking into account the Accredited Prior Learning (APL) and Accredited Prior Experiential Learning (APEL) of nurses of different backgrounds and experience.

Model 1. For Experienced A and E Nurses

This is a shortened child branch programme which would include compulsory and optional theoretical and practical skill modules from the existing child branch Diploma or Degree programme. In addition there should be opportunities to expand the present skills of experienced nurses to an advanced level by incorporating the knowledge requirements for ENP status. Paediatric Advanced Life Support (PALS) and child protection modules should be incorporated into the curricular framework. On completion of this programme, these senior nurses would continue to build upon newly acquired knowledge by application to their practice on completion of the "Children in A and E" course and subsequently would be competent and qualified to care for children, to eventually be awarded E.N.P autonomous and specialist practitioner status.

Model 2. For Junior Children's Nurses

This model allows junior children's nurses, with a basic children's nursing qualification (RN Child), who wish to be employed solely with children in A and E, to undertake A and E training specific to children. In addition to the necessary knowledge and skills of trauma nursing it would also include the Paediatric Advanced Life Support (PALS) training and a

child protection module. Subsequently and with considerable further experience in A and E with children, these nurses might also develop to autonomous and specialist nurse practitioner status.

Model 3. For New General Nurses

This model is for newly qualified general nurses who wish to care for both children and adults in A and E units. They should undertake a full time combined A and E and Child Branch pathway incorporating a PALS and child protection module. The length of their course (as in the other two models) will depend upon whether or not they have any credits via APL or APEL.

All of the above models would need to be designed within either a diploma or degree pathway. A practical barrier for the introduction of these models is likely to be the lack of University resource to carry out the initial in-depth assessment of student need and prior experience via a portfolio and hence the design of individual curricula content and delivery mechanisms. The institutes who currently deliver the child branch Diploma or Degree option as well as the A and E pathways have the systems to accommodate the flexibility of delivery mechanisms and recognition of APL and APEL but need the support of the University and the opportunities to progress to degrees including higher degrees. This might lead to a second practical problem, as each module will need to be assessed at the level that can be transferred towards qualifications ranging from Diploma to Masters Degrees. Multi-level assessment strategies would need to be in place in the Universities. This structure would make such programmes meet the needs of individual nurses and be attractive to them, in addition to being viable and attractive to the Trusts as employers and to their managers who have to consider their local resource requirements.

There is a substantial need for experienced clinicians to be in partnership with the educational institutes in order to minimise the theory-practice gap. It is important that such clinicians drive the skills content of the curricula and also that they support the methods of assessment of skills in practice. Within this researcher's experience, practice managers do not give Pathway Management Meetings a priority amongst their commitments. It is recommended that they delegate this role to senior ward or A and E children's nurses. They would have much to contribute to the pathway and module management teams in the educational establishments.

In the district general hospitals in this study it is evident that children are not seen as distinctly different to adults and are not often being cared for by suitably skilled nurses. To the best knowledge of this researcher there are only two universities (London-based) offering discreet educational modules to adult registered nurses, for the care of children in A and E. Many more are needed to meet the demands of all of the Trusts. This need must be emphasised to both practice and educational managers of sufficient seniority to encourage them to offer solutions to the commissioners of education representing the Trusts who pay for nurse education and training.

There is considerable literature support for children's nurses in A and E needing to be both an advocate for their clients and also to be an educational resource. This researcher recommends that advocacy should extend further than the clinical area and should include informal lobbying for improved care and services for children locally and nationally. Children's nurses should also manage and delegate care. They are educated to meet the children's holistic needs including emotional care and preparation for treatment through distraction and play therapy. But due to their limited numbers and the pressures of other priorities they cannot be directly involved or "hands on" in all of those areas.

Most play therapists are nursery nurses who have undertaken a level 3 NVQ qualifications and their training includes the care of sick and well children (Barnes 2000). For this reason they are likely to be more competent to meet the emotional needs of children than unqualified nurses and health care assistants. They also have more skill and a much stronger focus on play and distraction therapy than children's nurses who nevertheless share the same knowledge about it's importance. Hence they can be employed as an aide to the children's nurse. Their clear focus on play and distraction therapy was very evident during observation of these nursery nurses in Unit A. Nursery nurses were employed in Unit D; the children's hospital, but were not present during the observations. The sisters confirmed their value to the A and E team but commented that insufficient numbers were employed to cover all shifts. Nursery nurses were not employed in Unit B; the DGH with a non child-friendly focus. Perhaps they were not employed in Unit B because their value was not recognised by management. If they had been employed, it is reasonable to assume that they would have improved the physical and emotional environment for children. The employment of increased numbers of nursery nurses is recommended for all A and E departments where children are cared for, to be employed at level one of the new career structure which is proposed to replace clinical grades (DoH 1999a). The nursery nurse would encourage and expect all staff to utilise distraction therapy. This recommendation does not imply that nursery nurses could replace children's nurses in A and E; the latter should direct the care given by the nursery nurses. This would improve the effectiveness of the multidisciplinary team in A and E.

9.3 Recommendations for Further Research

This research took place in a small selection of A and E Units in one geographic area of England. There is no guarantee that if this study were reproduced with other Units in another

part of the UK by this researcher or another researcher that exactly the same findings would result. However, the literature survey and triangulation of the data from phases 1, 2 and 3 of this study confirms that children's nurses meet the needs of children in A and E more effectively than nurses trained solely to care for adults. The Delphi panel only included experienced nurses from England; nurses from Scotland, Wales and Northern Ireland would have enhanced confidence that the views expressed by the panel are applicable to all of the UK. This is important because the UKCC assumes responsibility for all of the UK. The panellists were involved in two rounds of that study. A third round was considered inappropriate at the time because of the work pressure on the panellists who were all busy people. A third round would have added value to their prioritisation of the required knowledge, skills and attitudes and might possibly have reached a consensus of opinion. On the other hand, if three rounds had been identified as required at the outset of the Delphi study then it might have been difficult to recruit an effective panel.

From both the analysis of the data and from the discussions of the findings, further areas for research has been revealed. Some of these areas would further contribute to the outcomes of this study. Other areas are outside the specific domain of this research although the ideas and hence recommendations are a by-product of it. The research was specific to the care of children in A and E by nurses. Children receive care from many heath care professionals and team working is essential. Research into the factors which develop effective A and E teams for the care for children, including the need for and feasibility of multi-skilling, would be beneficial to all of the stakeholders. This research raised questions but could not fully explain the importance of the appointment of paediatric medical consultants to an A and E unit in the context of influencing holistic care culture in that unit and by leadership or otherwise influencing the attitudes of the rest of the staff towards children. Models of care which focus

on the medical care rather than upon holistic care were found to be operating in most of the Units in this study. The parallel between the appointment of a paediatric medical consultant for children who may or may not work to a holistic care model and the culture and physical environment and operating protocols and practice of a Unit caring for children is recommended as an idea for further research.

There is a need to evaluate the existing shortened training programmes being offered to adult nurses who care for children in A and E. These shortened programmes are a direct result of the urgency of the problem of insufficient numbers of qualified children's nurses. But it is important to check that these programmes at least maintain the current standards of competence of newly trained children's nurses. This study provides many benchmarks which can contribute to a national standard of occupational competence for such nurses.

Child protection training is mandatory for all nurses who care for children. Nurses must also be screened against police records for related offences. Instances of child abuse by hospital staff including nurses are fortunately rare but a study to determine the reality and degree of thoroughness of such employment checks and staff training in A and E is recommended. The current study does include aspects of child protection; but a comparative study of professionals who work in A and E is also timely. It could compare the effectiveness of staff that have received formal child protection training with those who have not.

Adolescent behaviours and response to trauma is the focus of much debate in the NHS and the literature reviewed for this study provides limited information about their care needs. However, many of the respondents in this study were unable to distinguish between the care needs of adolescents and those of children. Further research to explore whether this is a

widespread problem amongst nurses is recommended. If it is a significant problem there will be implications for their training needs.

This study has identified many of the features of best practice for nursing children in A and E. But the quality of care that children receive is, of course not just dependent upon the skill and expertise of nurses but upon the effectiveness of the complete Unit; its physical environment, protocols and operating systems and all of its resources. Exchange of best practice information between Units could be advantageous. Benchmarking A and E Units against best practices for the care of children is recommended. Benchmarking is not research, and can and should be carried out by the Units themselves, with support from a facilitator. Tools that can be used have been identified by this study and include the framework "Essence of Care" (DoH 2001) and the best paediatric nursing practice statements for Accident and Emergency provision from the University of Central Lancashire (1997).

9.4 Summary

This the first study to identify knowledge skill and attitudes in such a detailed, systematic way, using experts and then comparing these initially with the knowledge, skill and attitudes that staff think they have, and finally to those observed in practice. Thus the study has identified "gaps" in the training of adult nurses, caring for children in A and E, by both questioning through a staff survey and by observation in the clinical area.

The results from the Delphi study, a survey of practicing nurses and observations in A and E have been compared and contrasted with each other and with the literature survey and this triangulation has led to the identification of a number of key findings. Some of these outcomes make direct and essential contributions to the overall aim and research goals of this

study. Others are more indirectly related to the study but add value to it and have therefore been discussed.

In essence the key outcomes or conclusions are that the care needs of traumatised children are different from those of adults, but that the majority of them are not at present cared for by nurses with the necessary competence or within an appropriate environment. Most A and E nurses are trained to care for adults and not children, and most A and E environments and operating practices have been developed without taking into account the developmental stages of children and the opportunities for positive benefits to their care which are presently being missed in the District General Hospital A and E units. Children need holistic care, not just the treatment of their medical injury. There is an education and training challenge because most of the nurses in this survey who do care for traumatised children think they are competent in that specific and distinct role, although the observations show that this might not always be the case. Nurses should be trained in both paediatric and A and E nursing skills. This can and should be achieved by personalised and flexible courses.

The recommendations which are consequent upon the key outcomes have been addressed separately to education and training providers, to the nurses themselves and finally to the health care policy makers and managers who control the environment within which A and E child care takes place.

The recommendations to the education and training providers were firstly specific to the content of the curricula for training children's nurses and secondly to the structure of the corresponding courses. The courses should be structured to meet the needs of their customers; the nurses who become their students and the managers of those nurses who second them to

the courses and are the paying customers. In practice this means that the delivery should be flexible and personalised to the individual trainee because, as this study shows, they will have different levels of initial competence.

Adult-trained nurses, however expert in that context, are recommended to seek the advice of their child-trained colleagues who care for children. The qualified children's nurses in A and E, all of whom are trained to care for children on a holistic basis, are encouraged to promote that philosophy in the A and E environment even when it is not the prevailing culture.

Managers are recommended to work with education and training providers to support three different models of continuous professional development; models which reflect the different backgrounds and initial levels of competence of nurses who care for children.
These three models are for experienced A and E nurses, for junior children's nurses and for new general nurses. Managers are also recommended to employ more nursery nurses in A and E to be aides to the qualified children's nurses and to improve the effectiveness of the multi-disciplinary A and E team.

If these recommendations are acted upon then nurses caring for children will be better educated and in turn the practices of caring for traumatised children in A and E will also improve. These were the overall aims of this study.

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(Editors)

APPENDIX 1a.

22 Nov. 1999

Dear

Re Research Study: "The Educational Needs of Qualified Nurses Caring for Children following Trauma".

I am a lecturer in Child Health at the University of York, and for my doctorate, I am researching the education and training needs of qualified nurses working with children in Accident and Emergency departments.
This involves surveys and observation in five Accident and Emergency Units in **. I have selected ** Children's Hospital as the only children's hospital in ** and which I anticipate will be the Trailblazer.

I have attended an ethics committee in a large District Hospital where the research proposal was approved. Hence, **(Research Nurse) and **(Paediatric Consultant) were satisfied that this would suffice for ** Children's Hospital Trust.

The rules of anonymity will be respected and I seek your consent for me to spend between three and four shifts as a participant observer in the Accident and Emergency unit, which could include conversational interviews with any staff involved with the children's care.

Thank-you for your attention and I await your response with interest.

Yours sincerely

Christine M. Hall MSc (Child Health); B.Ed.(Hons); RGN; RSCN; RHV; Cert. Ed.

APPENDIX 1b.

Please respond to

Dear

Re Research Study:

"The Educational Needs of Qualified Nurses Caring for Children following Trauma".

Further to our meeting, I wish to introduce my intended research, and apologies for the length of time elapsed.

As you might remember, I am presently employed as a lecturer in Child Health at the University of York. and for my Doctorate am researching the education and training needs of qualified nurses working with children in Accident and Emergency Departments.

This involves surveys and observation in five Accident and Emergency Units in Yorkshire. I have selected ** District General Hospital, as I am aware that you receive a large number of children into the department and also because you employ at least one qualified Children's Nurse.

I seek consent to send a questionnaire to all the qualified nursing staff in A/E. On agreement, could you please let me have the names and grade of your qualified staff working in the department.

I may also require spending the maximum of two observational periods as a *participant* observer in the Accident and Emergency Unit, which could involve observation of children's care and conversational interview with any staff involved in children's care.

I enclose details of the research methodology for your interest and guarantee that all written reports will observe the rules of anonymity. That is the identity of ** District Hospital A and E department and its staff will be protected at all times. No names will be included in any documentation.

I know that you are very busy and hence thank you for your support and await your response. If you wish further clarification, do not hesitate to contact me.

Thank you for your attention

Yours sincerely,

Christine M. Hall MSc (Child Health) B.Ed. (Hons) RGN, RSCN, RHV, Cert. Ed.

APPENDIX 1c.

Please respond to

Dear

Re Research Study:

"The Educational Needs of Qualified Nurses Caring for Children following Trauma".

Further to my application to ** Ethics Committee, I wish to introduce my intended research and myself.

I am a lecturer in Child Health at the University of York. and for my Doctorate, I am researching the education and training needs of qualified nurses working with children in Accident and Emergency Departments.

This involves surveys and observation in five Accident and Emergency Units in **. I have selected ** District General Hospital Trust, as I am aware that you receive a large number of children into the department and also because you employ some qualified Children's Nurses.

I have received agreement from the Ethic's committee subject to your approval and that of ** (Nurse Manager), whom I have also written to. Dr ** has requested that a letter of consent be sent to him should you agree to my proposal.

I seek your consent for me to send a questionnaire to all of the qualified nursing staff in A and E. Also to spend the maximum of three shifts as a *participant* observer in the Accident and Emergency Unit, which could involve observation of children's care and conversational interview with any staff involved in children's care.

Other hospitals taking part in the survey are prepared to offer me an honorary contract for the three shifts that I intend to spend undertaking the *Participant* Observation. This is something that I intend to pursue with ** (Nurse Manager).

I enclose details of the research methodology for your interest and guarantee that all written reports will observe the rules of anonymity. That is the identity of *** A and E department and its staff will be

protected at all times. No names will be included in any documentation.

I await your response and guidance to any further arrangements that I need to undertake, if you wish further clarification, do not hesitate to contact me or I shall be pleased to make a mutually convenient date to meet with you.

Thank you for your attention

Yours sincerely,

Christine M. Hall MSc (Child Health) B.Ed. (Hons) RGN, RSCN, RHV, Cert. Ed.

APPENDIX 2.

Christine M. Hall MSc, B.Ed. (Hons) RGN, RSCN, RHV, Cert Ed.

(Doctor ate in Education (Ed. D.)
University of Huddersfield

Research Proposal.

Title

The Educational needs of qualified nurses caring for children following trauma.

Research Question

Are the knowledge, skills, and attitudes of qualified nurses sufficient to meet the needs of children attending hospital following trauma?

Aims

1. To identify the knowledge, skills and attitudes required for nurses caring for children following trauma.

2. To investigate the day to day practice, interaction and skill of nurses caring for children following trauma.

3. To identify the gap between the requirements identified and actual practice, and hence to make recommendations for educational developments and curriculum planning.

Introduction and Rationale

On average 25 -33% of the total number of Accident and Emergency attendees are children under 16 years (BPA, 1998) and the Royal college of Nursing Accident and Emergency Special Interest Group (RCN, 1995, 1996) state that this figure can be as high as 45% in some departments.

Whatever the statistics, Smith (1997) reports that children are more likely to be admitted to Accident and Emergency than through planned admission into a hospital environment. Muller et al (1992) emphasises that 44 % of all children will have visited an Accident and Emergency unit by the age of 5 years.

Smith further describes the fearful environment of distressing sights and sounds for which children are more often than not ill prepared. Court (1976) advocated a separate facility more than twenty years ago. It is widely recognised that children require separate hospital facilities but present day resources do not make this a reality or indeed a priority in many District General Hospital Accident and Emergency departments. This lack plus the shortage of qualified children's nursing provision may result in children's needs not being met, and hence a diminished quality of care.

Following a survey of 189 large Accident and Emergency departments by the British Paediatric Surgeons (BPA, 1985) only 15% employed at least one Registered Sick Children's Nurse (RSCN). The charity Action for Sick Children found similar patterns in 1991 and produced an outline of recommended standards for emergency health services for children and young people. The Audit Commission (1998) recommended that children should receive care from specifically skilled staff in facilities designed to meet their needs and confirmed that RSCNs are essential but often absent.

The Health Select Committee for Children's Services in Hospital (HSCCSH, 1997) recommended to the Department of Health (DoH), that regional offices need to identify and publish a target date by which it expects all health authorities to be purchasing Accident and Emergency services for children. Hence the HSCCSH (1997) reports are timely in formalising and facilitating appropriate standards for Child Health Care.

Research evidence is limited in this area, but Burgin (1993) identified the way in which nursing staff of an Accident and Emergency department cared for children and responded to changes arising from the opening of a newly developed children's area. She described how many nurses demonstrated a lack of knowledge of the child's physiological differences, and she pointed out that children's nurses would bring expertise to Accident and Emergency Departments. However, she did not detail these skills, although those of communications, pain management

and family involvement were mentioned. Clearly, more research is required to highlight the skills required.

With approximately 3 million children attending Accident and Emergency each year, many do not see a suitably skilled children's nurse (Shelley, 1991). However, there is much evidence stating that children coming into hospital should be cared for by a qualified children's nurse. One of the reasons is that there is a national shortage of children's nurses (Smith 1997). Many Accident and Emergency departments are encouraging keen qualified Accident and Emergency nurses to convert to qualified children's nurses, whilst others are reluctant to do so.

RSCNs convert from general nursing by undertaking an educational programme of at least one year full-time study, which prepares them to care for the child's total health care and illness needs. However, the reality of this length of training programme is difficult to support in many departments.
It is also impractical to appoint the newly qualified nurse diplomats who have undertaken a Child Branch programme. If working in a General Accident and Emergency department, they will lack the necessary skills to manage adult patients.
Burgin (1993) recommended that the preparation for the care of children should be included in post registration pathways. These recommendations may not be practical because it may not be possible to extend the existing large curriculum content. Therefore other educational routes need to be explored.

This research will identify the knowledge, skills and attitudes needed by nurses caring for children in Accident and Emergency units following trauma. Hence it will make recommendations for the future educational preparation of highly skilled general Accident and Emergency specialist nurse practitioners.
It is timely to make suggestions for existing non- children's nurses to be offered a specifically defined programme to meet the standards recommended by the professional and statutory bodies advocating for children. The output from this research will provide a basis for such programmes.

** A and E department is a unit employing a number of children's nurses, hence it is a particularly good unit to investigate the benefits that such suitably skilled nurses have brought to the department.
This unit will form part of the investigation including stage 2 and 3 of the full doctorate research study.

Focus of the Proposed Study

The proposed research will be based on documentary evidence in addition to inquiry, observation, and analysis of a sample of Accident and Emergency Departments in the UK. The stratified purposive sample of departments will include the following criteria:

1. An Accident and Emergency Department in a Children's Hospital
2. A Regional Accident and Emergency Children's Unit in a General Hospital
3.* **A District General Hospital Accident and Emergency Department employing Children's Nurses**
4. A District General Hospital Accident and Emergency Department not employing Children's Nurses.

*** Highlights the ** District Hospital Trust Accident and Emergency Unit**

Research Design and Methodology

Stage 1
Delphi Technique

This technique requires the cooperation of a panel of experts who will be asked to complete a series of instruments to determine expert opinion on:

Identifying the requirements in terms of knowledge, attitude, competency, and skill when nursing a child in Accident and Emergency.

Sample

The sample under consideration is a panel of 20 (to hopefully receive 12 responses) experts working in children's hospital Accident and Emergency departments or lecturing in an educational setting on the Paediatric Accident and Emergency, ENB pathway.

Stage 2

Investigative Research: Staff Survey (Questionnaire)

Aim

To assess knowledge attitudes and skill of nurses who are caring for children in a variety of Accident and Emergency settings.

Sample

A Purposive and Convenient Sample of 200 qualified nurses, with different qualifications and experience and commitment to children.

Data will be subjected to qualitative and quantitative statistical analysis.

3. Stage 3 Concept Analysis Qualitative Research

Aim

To assess and observe knowledge attitudes and skill of nurses who are caring for children in a variety of Accident and Emergency settings, through Participant Observation

Sample

A sample of 4 Units will be utilised to observe the care of children following trauma visiting Accident and Emergency during a specified period.

Analysis

Analysis of Data will be undertaken utilising a qualitative approach.

Ethical Considerations

It is intended that this proposal will go through each of the Hospital's Ethical Committees, as ethical decisions are central to this study and relate to the adherence to the professional, legal and social obligations of the research subjects (Polit and Hungler 1994). The three main ethical principles that need to be incorporated into this research study are beneficence, respect for human dignity and justice. (Polit and Hungler 1994).

The immediate issues for consideration will be as follows:

- Unnecessary harm to any Child Participant.
- Informed Consent and Observation of the Rights of any Child and Adolescent
- Anonymity, Confidentiality And Confirmation Privacy
- Sensitivity And Diplomacy,
- Vulnerability Of Children and their Families
- Protection of Identity.
- Role Conflict

- Response to Distress.

Justice will be observed through anonymity, confidentiality and by confirming privacy of the subjects under observation.

Informed consent is an essential component and ethical permission has been granted from one-hospital ethics committee who has scrutinised this research proposal.

Proposed Plan of Research

	Description	Time Plan
1.	Research Proposal	January 1999
2.	Extended Literature Review	Dec. 1999
3.	Gaining Hospital Access and Ethical Committee Approval	September 99
4.	Delphi 1st round data collection	September 99
5.	Delphi 2nd round data collection	November 99
6.	Data Collection of stage 2 and 3	March 2000
7.	Analysis of Data to Date	September 2000
8.	Supporting the Resulting Theory with Literature	December 2000
9.	Considerations Arising form the Study and Educational Implications.	February 2001
10.	Reflections, Evaluation and Conclusions	April 2001
11.	Completion of Thesis	June 2001
12	Presentation	July 2001

Summary of Methodology

The Delphi study is designed to address the first aim of the research, that is to identify from experts, who are in the main managers within the profession, the skills, knowledge and attitude, required to fulfil the criteria to meet effectively the needs of children undergoing trauma care.

The results of this study will allow those attributes to be further invcstigated through the second and third stage of the study.

The second aim intends to investigate through questionnaires to existing staff working in the field, what they perceive as the necessary attributes (skills, knowledge, and attitude) for managing nursing care for children undergoing trauma care. This will be compared with the results of the Delphi study and any differences or similarities analysed.

On completion of the initial 2 stages, participant observation intends to verify or contradict the resulting data of the Delphi and Questionnaire Investigation. The observational part of stage 3 will identify the reality of the practice of nurses working with children, in the accident and emergency units.

This will confirm or identify any obvious discrepancies between the theoretical data obtained and the actual practice observed, which will be debated, in light of the literature, with recommendations offered for educational developments and curriculum planning. It is anticipated that the recommendations will need to take into account the changing health care needs, the environment, the support for managers to allow in-service training needs to be met as well as offering suggestions for meeting these requirements during pre-registration nurse educational syllabi.

APPENDIX 3.

Delphi Study

"Educational needs of qualified nurses caring for children following trauma"

A brief description of this research is attached for your attention. This delphi tool intends to identify the requirements, in terms of knowledge, attitudes, skill and competency needed by qualified nurses caring for children and adolescents (0 – 16 years) in any Accident and Emergency department following trauma.

(Trauma is defined as a wound or injury.)

Code No:

Would you please complete the following?

1. Name of your Job Title

2. What classification of Title do you have?

Manager ☐ **Sister/Charge Nurse** ☐ **Staff Nurse** ☐ **Other** ☐

If other please state

2. What grade of Appointment do you currently hold?

(Please tick the appropriate box)

I ☐ **H** ☐ **G** ☐ **F** ☐ **E** ☐ **D** ☐ **Other** ☐

If other, please state

4. Are you Male or Female? **(Please tick the appropriate box)** **Male** ☐ **Female** ☐

5. What Qualifications do you hold? (Please tick boxes that apply)

RGN (SRN)	RSCN RN Child	ENB 199	First Degree	Masters Degree	Other
☐	☐	☐	☐	☐	☐

If other please state:

6. What Qualifications, if any, are you currently working on/undertaking etc.?

Please state

7. How do you keep up to date?

Journals	Books	Study days	Conferences,	In-service	Other
☐	☐	☐	☐	☐	☐

If other please state:

8. Length of experience in caring for children in Accident and Emergency.

Under 1 year	1< 3 years	3 < 5 years	5 < 10 years	More than 10 years
☐	☐	☐	☐	☐

9. What type of Hospital? (Please tick the appropriate box)

Regional Unit	District General Hospital	Other
☐	☐	☐

If other, please state:

10. What type of Unit? (Please tick the appropriate box)

Adults	Adolescents	Children	Other
☐	☐	☐	☐

If other, please state

11. What type of Clients? **(Please tick the appropriate box)**

Children	Children and Adolescents only	Adults and Children only	Other
☐	☐	☐	☐

If other, please state ☐

12. Please list the basic UNDERPINNING KNOWLEDGE that you consider ESSENTIAL AND DESIRABLE for nurses caring for children in accident and emergency following trauma.

	Knowledge of child friendly pain assessment tools	Essential Please tick √	Desirable Please tick
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Comments

13. Please list the **ATTITUDES** that you consider **ESSENTIAL AND DESIRABLE** for nurses caring for Children in Accident and Emergency Units, following trauma.

	Friendly	**Essential Please tick √**	**Desirable Please tick**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Comments

14. Please list the **SKILLS/ COMPETENCIES** that you consider **ESSENTIAL AND DESIRABLE** for nurses caring for Children in accident and emergency following trauma.

	Changing a nappy **Accurately monitor a child's temperature**	**Essential** **Please tick** √ √	**Desirable** **Please tick**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Comments

APPENDIX 4.

Delphi Study Second Round

"Educational needs of qualified nurses caring for children following trauma"

Thank you for responding to the first round of my Delphi study.
The results of the round have been collated and this second and final round intends to identify the importance of the responses, which were received.

Three sections are included in terms of :

2. Knowledge
3. Attitudes
4. *Skill and Competency*

that you assessed as necessary for qualified nurses, caring for children and adolescents (0 to 16 years) in any Accident and Emergency department following trauma.
(Trauma is defined as a wound or injury.)

Code No:

Would you please complete the following by ticking the appropriate box and offering a score between 1 to 5 for each item according to importance?

1.	**KNOWLEDGE**						
		Most important					**Least important**
		5	**4**	**3**	**2**	**1**	**Total**
Paediatric Basic Concepts							
E.G	**Age of Child's Development**						
	Physiology						
	a) Psycho-social						
1	Cognitive Development						
2	Psychological response of child						
3	Behavioural norms						
4	Communication skills verbal						
5	Communication skills non-verbal						
6	Children's needs						

7	Knowledge of play							
b) Physiological								
8	Anatomical differences of child							
9	Physiological differences of child							
10	Physiological responses of child							
General Paediatric Knowledge								
11	Good all round health assessment							
12	Pain Assessment							
13	Vital signs - normal ranges							
14	i) Temperature							
15	ii) Pulse							
16	iii) Respiration							
17	iv) Blood values							
18	v) BP							
19	Fluid balance							
20	Neurological function							
21	Child abuse							
22	Child Protection Procedures							
23	Family Centred /Negotiated Care							
24	Wound care							
25	Pharmacology							
26	Drug dosage							
27	Appropriate use and Routes of Administration							
28	Consent Issues							
29	Use of equipment							
30	Immunisation and vaccination schedules							
Accident and Emergency Paediatric Nursing								
	General							
31	Triage skills							
32	Fracture management							
33	Glasgow coma scale							
34	i) Understand							
35	ii) Interpret							
	Trauma and Resuscitation							
36	Trauma Process							
37	Trauma team management							
38	Paediatric Airway management							
39	Maintenance of Child's circulation							
40	APLS (Paediatric Basic Life Support)							
41	PALS							
Professional Nursing Knowledge								
42	Calm Confident manner							

43	Ethical and Moral Issues						
44	Departmental safety issues						
45	Accident Prevention and referral						
46	Identify need for health promotion and accident prevention.						
47	Liaison with Primary Health care Team						
48	Community Resource						
2. ATTITUDES							
1	Approachable						
2	Patient						
3	Understanding						
4	Adaptable						
5	Caring						
6	Pleasant						
7	Happy (as appropriate)						
8	Efficient						
9	Knowledgeable						
10	Friendly						
11	Calm						
12	Sense of humour						
13	Non- Judgmental						
14	Sensible						
15	Trustworthy						
16	Professional						
17	Open						
18	Good Communication skills						
19	Good Communicator						
20	Competent						
21	Good team worker						
22	Kind but firm						
23	Consistent						
24	Accepting						
25	Reassuring						
26	Supporting						
27	Willing to share care						
28	Patience						
29	Flexible						
30	Open to change						
31	Decisive						
32	Empathetic						
33	Systematic						
34	Level headed						
35	Cheerfulness						
36	Outgoing						
37	Sympathetic						

38	Tolerant							
39	Skilful							
40	Kind							
41	Compassionate							
42	Attentive							
43	Honest							
44	Organised							
45	Welcoming							
46	Non- prejudicial							
47	Listener							
48	Sharing of updated knowledge with colleagues							
49	Willingness to influence health policies							
	Child and Family Friendly							
50	Good converse with Children all ages							
51	Aware of family needs							
52	Informative to parents							
53	Allay parental anxieties							
54	Approachable to child							
55	Non- Threatening dress							
56	Communicative to level of child							
57	Tune in to Child's current emotional state							
58	Barriers of professionalism broken down when communicating with children							
59	Act as Parental advocate							
60	Confident to child and family							
61	Responsive to child and family anxiety							
62	Empowerment of parents and decision making							
63	Appropriate to child and family							
64	Respective to all							
65	Respects the needs of Children, Young People							
66	Respects the knowledge/ skill of colleagues							
67	Promotes team work							
68	Confidentiality							
69	Willingness to listen							
70	Unhurried attitude							
71	Demonstrates a liking for children							
72	Child friendly							
73	Enjoy Paediatric nursing							
74	Sensitive to children's needs							
75	Belief in rights of child and family							
3. SKILLS / COMPETENCIES								
General Paediatric Nursing Skills								
1	Accurate measurement of height and weight							
2	Taking and Recording Vital signs							

3	Pain management							
4	Calculation of drugs							
5	Administration of medicines							
6	Administration of nebulisers							
7	Administration of Fluid replacement							
8	Management of children's medical equipment							
9	Play							
10	Distraction and play therapy techniques							
11	Reassurance to child and family							
12	Health promotion							
13	Verbal communication							
14	Non-verbal communication							
15	Teaching Child and family							
16	Counselling							
17	Nappy changing							
18	Collection of specimens							
19	Use of Glasgow Scale							
20	Specialist Nurse Practitioner degree							
Accident and Emergency Skills								
	Assessment							
21	Accurate use of Breslow tape							
22	Rapid and accurate Assessment of child							
23	Observation of changes							
24	Ability to: Predict							
25	Interpret							
26	Present							
27	ECG assessment							
	Management							
28	Management of fractures							
29	Immobilisation and splinting							
30	Application of a Thomas Splint							
31	Application of Plasters							
32	Dressings and bandaging							
33	Wound care							
34	Wound closure							
35	i) Gluing							
36	ii) Steristripping							
37	iii) Suturing							
38	TNCC/ ATNC							
39	Paediatric ENP course skills							
40	Phlebotomy							
41	Venepuncture							
42	Cannulation							
43	IV drug administration							
44	Intra-osseous infusion							

45	Administration of Entonox						
46	Intubation						

I wish to thank you for your co-operation in my study and in particular with this questionnaire.

Chris Hall.

APPENDIX 5.

7 Mar 2000

Dear Colleague

Re Research Study:

The Educational Needs of Qualified Nurses Caring for Children following Trauma.

I am presently employed as a lecturer in Child health at the University of York, and for my Doctorate am researching the education and training needs of qualified nurses working with children in accident and emergency departments.

This involves questionnaires, surveys and observation in five accident and emergency units in Yorkshire. I have selected **, as I am aware that you receive a large number of children into the specific paediatric department and also because you employ qualified children's nurses.

I enclose details of the research methodology for your interest and guarantee that all written reports will observe the rules of anonymity. That is the identity of ** A/E Department and its staff will be protected at all times. No names will be included in any documentation.

I know that you are busy and hence thank-you for your support and request that you return the completed questionnaire to me by **March 31st, 2000.**

Alternatively Sister ** has agreed to collect the completed questionnaires and can be delivered to her by that date.

I await your response and if you wish clarification, do not hesitate to contact me. (YDH 01904 453996)

Yours sincerely

Christine M. Hall: Lecturer

APPENDIX 6

Staff Survey – Introduction to the Research Aims and Objectives.

Christine M. Hall MSc, B.Ed. (Hons) RGN, RSCN, RHV, Cert Ed.

(Doctorate in Education (Ed. D.)
University of Huddersfield

Title

The Educational needs of qualified nurses caring for children following trauma.

Research Question

Are the knowledge, skills, and attitudes of qualified nurses sufficient to meet the needs of children attending hospital following trauma?

Aims

- **To identify the knowledge, skills and attitudes required for nurses caring for children following trauma**
- **To investigate the day to day practice, interaction and skill of nurses caring for children following trauma.**
- **To identify the gap between the requirements identified and actual practice, and hence to make recommendations for educational developments and curriculum planning.**

Focus of the Proposed Study

The proposed research will be based on documentary evidence in addition to inquiry, observation, and analysis of a sample of Accident and Emergency Departments in the UK. The stratified purposive sample of departments will include the following criteria:

1. An Accident and Emergency Department in a Children's Hospital
2. A Regional Accident and Emergency Children's Unit in a General Hospital
3. A District General Hospital Accident and Emergency Department employing Children's Nurses
4. A District General Hospital Accident and Emergency Department not employing Children's Nurses.

Research Design and Methodology

Stage 1
Delphi Technique

This technique requires the cooperation of a panel of experts who will be asked to complete a series of instruments to determine expert opinion on:

Identifying the requirements in terms of knowledge, attitude, competency, and skill when nursing a child in Accident and Emergency.

Stage 2

Staff Survey (Questionnaire)

To assess knowledge attitudes and skill of nurses who are caring for children in a variety of Accident and Emergency settings.

Stage 3

Concept Analysis Qualitative Research

To assess and observe knowledge attitudes and skill of nurses who are caring for children in a variety of Accident and Emergency settings, through Participant Observation

Ethical Considerations

The immediate issues for consideration will be as follows:

- Confidentiality, Honesty and Justice
- Unnecessary harm to any Child Participant.
- Informed Consent and Observation of the Rights of any Child and Adolescent
- Anonymity, Confidentiality And Confirmation Privacy
- Sensitivity And Diplomacy,
- Vulnerability Of Children and their Families
- Protection of Identity.
- Role Conflict
- Response to Distress.

Justice will be observed through anonymity, confidentiality and by confirming privacy of the subjects under observation.

Informed consent is an essential component and ethical permission has been granted from one-hospital ethics committees who has scrutinised the research proposal.

APPENDIX 7

Questionnaire – Staff Survey

" Educational needs of qualified nurses caring for children and adolescents following a wound or injury"

A brief description of this research is attached for your attention. This questionnaire tool intends to identify the requirements, in terms of knowledge, attitudes, skill and competency needed by qualified nurses caring for children and adolescents (0 – 16 years) in any Accident and Emergency department following trauma.

(Trauma is defined as a wound or injury.)

Code No: ☐

Please complete the following

1. Your Job Title

☐

2. Please indicate which of the following categories best reflect your level.

Manager	Sister/Charge Nurse	Staff Nurse	Other
☐	☐	☐	☐

If other please state ☐

3. What grade of appointment do you currently hold?

I	H	G	F	E	D	Other
☐	☐	☐	☐	☐	☐	☐

If other, please state ☐

4. Are you an RSCN or RN Child Branch?

Yes ☐ No ☐

5. What is your length of experience in caring for children and adolescents in Accident and Emergency.

Under 1year ☐ 1<3 years ☐ 3<5years ☐ 5<10years ☐ > 10years ☐

6. Please indicate your gender.

Male ☐ Female ☐

7. Please indicate your qualifications (please tick all that apply)

RGN (SRN) ☐ **RSCN** ☐ **RN Child** ☐ **ENB 199** ☐ **First Degree** ☐ **Masters Degree** ☐ **Other** ☐

If other please state: ☐

8. What qualifications, if any, are you currently working on/ undertaking etc.?

Please state ☐

9. How many children (0 –12 years) **do you care for in one week? (Please estimate)**

0-<5 ☐ **5-<10** ☐ **10-<20** ☐ **20-<30** ☐ **>30** ☐

10. In your opinion do children require any specific nursing care when compared to adult patients?

Yes	No	Unsure
☐	☐	☐

10. Please explain your answer to question 10.

12. Do you consider that you are able to meet the specific needs of children

Always	Mostly	Sometimes	Never
☐	☐	☐	☐

13. How many adolescents (13 – 16 years) do you care for in one week? (Please estimate)

0-<5	5-<10	10-<20	20-<30	>30
☐	☐	☐	☐	☐

14. In your opinion do adolescents require any specific nursing care?

Yes	No	Unsure
☐	☐	☐

15. Please explain your answer to question 14.

16. **Do you consider that you are able to meet the specific needs of adolescents?**

Always ☐ Mostly ☐ Sometimes ☐ Never ☐

17. **How knowledgeable do you feel about caring for children in? Accident and Emergency?**

Very knowledgeable ☐ Quite knowledgeable ☐ Not very knowledgeable ☐ Very unknowledgeable ☐

18. **How knowledgeable do you feel about caring for adolescents in Accident and Emergency?**

Very knowledgeable ☐ Quite knowledgeable ☐ Not very knowledgeable ☐ Very unknowledgeable ☐

19. **How do you feel about nursing children in Accident and Emergency?**

Very Confident ☐ Confident ☐ Anxious ☐ Very Anxious ☐

20. **How do you feel about nursing adolescents in Accident and Emergency?**

Very Confident ☐ Confident ☐ Anxious ☐ Very Anxious ☐

21. **How competent do you feel when nursing children in Accident and Emergency?**

Very Competent ☐ Competent ☐ Quite Competent ☐ Not Competent ☐

22. How competent do you feel when nursing adolescents in Accident and Emergency ?

Very Competent	Competent	Quite Competent	Not Competent
☐	☐	☐	☐

23. <u>What skills do you currently use when you are nursing an child in Accident and Emergency?</u>

24. <u>What skills do you currently use when you are nursing an adolescent in Accident and Emergency?</u>

25. What skills would you like to develop if you were on a Children in A/E course.

26. If you were to attend a Children in A/E course. What sort of course would you prefer?

E.g. Length of course / Assessment Style / Type of qualification

27. If you were to attend a Children in A/E course. What sort of attendance would you prefer?

Full-time	Part-time Day	Part-time Half-day	Distance learning	Web based learning
☐	☐	☐	☐	☐

28. What do you think are the FIVE most important things that need to be considered by a person designing a Children in Accident and Emergency Department course for non-children's trained nurses?

29. Further comments

I wish to thank you for your co-operation in my study and in particular with this questionnaire.

Chris Hall