Northern Ireland Practice and Education Council for Nursing and Midwifery

ME AND MY FAMILY
PERSON-CENTRED NURSING ASSESSMENT & PLAN OF CARE (Children’s and Young Person’s Record)

Guidance for Use

March 2018
Introduction

This Guidance relates to the ‘Me and My Family’ documentation for children and young people in an acute hospital environment. This guidance should also be read in conjunction with the Regional Standards for Person Centred Record Keeping Practice for Nursing and Midwifery.

The ‘Me and My Family’ document should provide evidence that a person centred nursing assessment, plan of care and evaluation has been completed, demonstrating the involvement of the child’s/ young person’s and where relevant parent or carer and that his/her needs and preferences have been taken into consideration, where appropriate. In addition, the record should reflect on going evidence of the care you provide.

In essence the nursing record is the only means to substantiate and provide evidence to the care provided by nursing staff demonstrating the value and contribution you make as a nurse and the continuity of care you have provided.

Consent

Verbal consent should be sought for procedures carried out on admission i.e. application of anaesthetic cream/insertion of venous cannula /venepuncture/rectal medication and on-going procedures throughout the stay of the child/young person. Consent should be documented in the record of nursing care and outcomes section, on each occasion.
This can be used four times (one admission and 3 re-admissions) with a maximum of four months duration from the 1st admission assessment. Thereafter a new document must be commenced.

**Re-Admission layout**

<table>
<thead>
<tr>
<th>1st RE-ADMISSION</th>
<th>Any changes Yes □ No □ if Yes, give details</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD/YOUNG PERSON’S MEDICATIONS</td>
<td></td>
</tr>
<tr>
<td>DATE: / /</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd RE-ADMISSION</th>
<th>Any changes Yes □ No □ if Yes, give details</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD/YOUNG PERSON’S MEDICATIONS</td>
<td></td>
</tr>
<tr>
<td>DATE: / /</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3rd RE-ADMISSION</th>
<th>Any changes Yes □ No □ if Yes, give details</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHILD/YOUNG PERSON’S MEDICATIONS</td>
<td></td>
</tr>
<tr>
<td>DATE: / /</td>
<td></td>
</tr>
</tbody>
</table>

The first admission boxes have a blue fill, 1st, 2nd and 3rd Re-Admission will have a yellow fill. Information in the blue fill boxes *must* be reviewed on each re-admission and the yellow fill boxes will facilitate recording any changes that have occurred in between each admission.
Signature Register

Only full signature should be used in this document. Initials reserved for other charts i.e. bed end charts.

Admission Assessment Tracking

This section should be completed if you are unable to complete the initial person-centred nursing assessment including the risk assessments. You should identify in the box provided which sections are still to be completed for handover to an appropriate member of staff.

Paediatric (National) Early Warning Score P(N)EWS and Other

P(N)EWS The admission score which is calculated from observations taken on admission to the clinical care setting should be recorded in this section.

Other an example could be head circumference

Re-Admission

This must be completed for each re-admission.
Ethnic Group

A list of Ethnic Groups can be found on page 24 taken from HSC monitoring forms, this is not a definitive list.

Valuables

It is important to ensure that children/young people and parents/carers are aware of trust policies regarding valuables including electronic devices. In some areas written advice maybe available and should be given to the child/young person/parent.

Re-Admission

Update valuables/aids and equipment section.

Check answers to - does the patient agree to information being shared and primary carer advised of admission are the same for each re-admission. If different, document on Page 32 – Record of Nursing Care & Outcomes of Care.
## Child Protection Register

This section must be completed according to Trust Policy and guidance.

### Understanding the Needs of Children in Northern Ireland (UNOCINI)

Each Trust has a policy related to the completion of the UNOCINI form when a referral to gateway services is required. You should follow the policy directions for your organisation.

### Palliative/End of Life needs

Should any palliative/end of life needs be identified, please record them within the record of nursing care and outcomes section.

### Re-Admission

Update any changes for each re-admission.
Birth History
This section should only be completed if relevant to current admission.

Immunisations
Immunisations schedule varies from year to year – document if up to date and details of the immunisation that have not been given.

Learning Disabilities
Refer to – HSC hospital passport and guidance notes accessed at:

Re-Admission

Update any changes and check if immunisations up to date for each re-admission.
**Child’s/Young person’s Medications**

While nurses no longer record the list of medications a child/young person takes, the role of the nurse is to consider a range of issues relating to safe medication management for individual children/young people and the two boxes in this section must therefore be fully completed.

‘Any additional information’ section is *not* to record the list of medications a child/young person takes. This section is intended for documenting the child’s/young person’s need regarding medication i.e. if assistance is required to take medication.

Where the child’s/young person’s own drugs may be considered for use, each nurse must follow their own local HSC Trust policy for enabling this to happen.

Consider enquiring about other routes of administration, for example topical application i.e. ointments/creams/emollients when assessing prescribed /over the counter medication.

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### Re-Admission

<table>
<thead>
<tr>
<th>1(^{st}) Re-admission</th>
<th>Any changes</th>
<th>Yes □ No □ If Yes, give details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child/Young Person’s Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date: / /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Update any changes on each re-admission.
‘The Child’s/Young Person’s/Parent’s Story’ section

As part of a person-centred approach it is critical for nurses to understand the child/young person’s view of his/her own health and wellbeing, where appropriate for each admission. This will in some cases include information from the parents or main carer. The priorities for the child/young person, his/her understanding of the need for admission and any fears or concerns he or she has, need to be recorded here.

The information shared by the child/young person should, where appropriate, be included in plans of care and evidence should be contained in the evaluation that these matters are being addressed.

Complete for each re-admission.
**Nursing Assessment – initial**

*Assessment of aspects of life* identifies the child/young person’s, normal/usual routine, baseline and preferences.

*The specific information* identifies acute and existing needs (including those that are self-managed).

**Breathing and Circulation**

‘Does the circulation appear compromised’ – Capillary refill time (CRT) can be used in conjunction with other vital sign measurements to assess the circulation. Record the site that is used i.e. forehead/sternum/fingers.

More information regarding vital signs can be found from the following 2013 publication:

https://www.rcn.org.uk/professional-development/publications/pub-005942

**Communication**

Children and Young people with Learning Disabilities, refer to their hospital passport if they have one. More information can be found from the following:

HSC hospital passport and guidance notes accessed at:


**Safety Awareness**

There may be a discussion required with the child/young person regarding sensitive issues. It is important that these details are discussed in private, where age appropriate or dealt with sensitively where a parent or carer is involved prior to recording in the nursing assessment and plan of care.
Complete for each re-admission.
Signatures

The nurse completing the initial assessment of the record must sign the relevant box at the end of the assessment section and where a nursing student has completed the process, the mentor or supporting nurse must countersign this section indicating that a valid assessment has taken place.

Only Registered Nurses and Nursing Students can record in this document.
There are five risk assessments of which three must be completed within six hours of the child/young person being admitted or a decision to admit being made.

All aspects of the risk assessments must be completed, including dates times and review dates, to ensure the risk assessments are valid.

### Risk Assessments within 6 hours

<table>
<thead>
<tr>
<th>Page 6</th>
<th>Page 10-13</th>
<th>Infection Preventions &amp; Control Admission Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 13</td>
<td>Page 21</td>
<td>Moving and Handling Risk Assessment</td>
</tr>
<tr>
<td>Page 14</td>
<td>Page 22</td>
<td>GLAMORGAN SCALE – Paediatric Pressure Ulcer Risk Assessment</td>
</tr>
<tr>
<td>Page 17</td>
<td>Page 27</td>
<td>Bed Rails Risk Assessment</td>
</tr>
</tbody>
</table>

### Ongoing Risk Assessments should be completed:

**Moving and Handling Risk Assessment**

if condition changes, transferred to another care setting or new equipment/aids put in place

- If the Child/Young person is not independent of all moving and handling activities then a plan of care is required (complete as per local policy)

**Glamorgan risk assessment**

if condition changes or transferred to another care setting

- If score **below 10** and the child is deemed **not** at risk, reassess weekly
- If the score is **10 or more** then follow trust guidance for frequency of assessment

**Bed Rails Assessment**

if the need arises and should be completed prior to use of bed rails as per trust policy and practice.

### Risk assessment completed within 24 hours

| Page 11 | Page 19 | STAMP – Screening Tool for the Assessment of Malnutrition in Paediatrics |

**ALL risk assessments should be used in conjunction with clinical judgement.**
Re-Admission

The 5 risks assessments must be completed on each re-admission.

**BODY Map and Table Page 24-25.**

There are 3 body maps that must be completed if required for each re-admission, with a table on Page 24 – the date entered will identify which re-admission it applies too.

*when skin has been visually checked and there is no tissue damage/marks/bruising/skin condition or other wounds record this in body table

**Discharge Information/Checklist**

A child/young person centred approach to discharge is critical to the person in your care successfully returning home and will contribute to his/her remaining at home for as long as possible.

This section is designed to be a check list to support a safe discharge process at the point of leaving a ward and should be completed by the nurse who is discharging the child/young person.

This is not discharge planning. Evidence of discharge planning should be recorded in the record of nursing care &outcomes of care section or as per local guidelines.

**Record of nursing care & outcomes**

<table>
<thead>
<tr>
<th>Person</th>
<th>Assessment</th>
<th>Plan of Care</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Using nursing assessment skills to identify the needs of the child/young person and family to identify next steps</td>
<td>Pre-Discharges Support</td>
<td>Look at the effectiveness of the plan to ensure the needs of the child are met</td>
</tr>
<tr>
<td></td>
<td>Including ongoing information of physical, emotional and social needs</td>
<td>Outcomes checklist</td>
<td></td>
</tr>
</tbody>
</table>

In this section record ongoing assessment, *plan of care/treatment/support and evaluation.*

*If PACE has not been implemented into your area of practice continue to use tradition methods as per local policy for example a careplan. Using the information gained through the initial assessment to inform the careplan.*
For further Information, please contact

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BELFAST, BT1 4JE

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This document can be downloaded from the NIPEC website www.nipec.hscni.net

March 2018