Should paediatric patients be cared for by paediatric tissue viability nurses?

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Many children who are unwell are cared for in non-specialist hospitals or by generic community nursing teams. If they develop a wound that wound care may be directed by the local tissue viability nurse, who is probably an adult trained registered nurse will minimal exposure to or experience of caring for children. Does this matter? Are they just the same wounds but at a smaller scale?

I would suggest not, children and particularly neonates have a very specific set of requirements. For example, we know that the skin on neonates is very different to those of adults (particularly those born preterm). Many products that we routinely use are not licensed for use on infants (under 3 years old) or babies (under 6 months old) because the rate of absorption differs. Young children develop pressure ulcers in a very different pattern to adults with their most common site being the back of the head due to the weight ratio between the head and the body. They also suffer significantly more from device related damage and extravasation injuries.

Children are born with or develop many life limiting diseases, which due to their very nature, are rarely seen in adult patients. Their family support structures are generally well formed, unlike dealing with adult patients there is an expectation of the family being very involved in the delivery of care. The psychological aspects of care vary considerably depending on the child's age and stage of development and can be an over riding factor in the planning and delivery of their care.. *Jacqui Fletcher*

1. Do you think non paediatric trained nurses should be delivering care to children and babies?

CG: Adult nurses will have developed knowledge and skills in Tissue Viability that could be transferred over to the paediatric population, however, it must be considered that children are not mini adults and therefore require to be cared for by nurses who specialise in Paediatrics.

The term paediatric ranges from preterm babies to 18 year old adolescents. As Jacqui has highlighted, there are considerable differences between the adult population and paediatrics regarding the stages of development, not just physically but also physiologically, emotionally and intellectually. As a result, it is imperative that the nurse caring for this population, with such diverse needs, has the appropriate knowledge and skills to provide safe and effective quality care.

Children who are born with rare syndromes and/or exceptional complex health needs may not progress in to adulthood. Therefore, the Adult nurse may lack the knowledge and experience in caring for such children effectively, as they will have different factors that affect the wound healing and therefore the treatment and management process will differ compared with adults.

I would therefore agree that wound management should be provided to the paediatric population by paediatric trained nurses.

GG: While I feel it would be ideal to have a paediatric tissue viability nurse for every paediatric team I think it would be very difficult to achieve in practice. I am the only community Tissue Viabilty Nurse (TVN) working on an island with a total population of around 105,000. We have one inpatient childrens ward and a small team of paediatric nurses working within community. To have a specific childrens TVN would not be viable. However I do feel the paediatric trained nurses and the TVN should work together, using the paediatric nurses specific knowledge of children and the TVN wound care expertise to achieve the best outcomes for the child/baby. The national/regional centres for children and babies have proven to be a useful resource for myself and paediatric colleagues when struggling with a specific issue that we lack experience/expertise in, hopefully making up for any gaps in knowledge from non paediatric trained TV nurse .

LR: In an ideal world, no. However, like many others there is a gap in the commissioning of paediatric services with regards Tissue Viability in my area. There are low numbers of children's referrals into my Community Tissue Viability Service and therefore I feel that a designated paediatric TVN is perhaps not seen as a need. Interestingly we do have a specialist nurse for children and young person's continence.

The NMC's opinion is that an adult trained

registered nurse may care for paediatric patients, but that the care given must remain within their scope of practice and competence. This allows me as an adult nurse to provide care for children requiring advice and support with wound care. Although I am deemed competent in my wound care practices with adults and children, my confidence in dealing with children as a patient group can differ greatly depending upon the age of the child.

The confidence you develop with children in your own family grows as you spend time with them and become accustomed to their needs, routines and the nuances of their communication.

With babies and infants I am completely reliant on the child's nurse and parents for feedback — have I hurt them, are they crying because they are distressed and in pain? Are they hungry? Soiled?

Older children are less scary! I feel much more confident, their skin is more developed and the older they are, the less to worry about in terms of absorption of potent active components of dressing products potentially causing toxicity or harm. We are taught in nursing that good communication is a key component in the provision of excellent nursing care. Older children for the most part, can give me the information needed during assessment, with further supporting history provided by their parents. This makes the decision making process much easier for me in terms of when to initiate or discontinue products or treatments.

2. What benefits do you believe paediatric trained nurse offers when caring for paediatric population with wounds?

CG: Children's nursing is unique. Providing wound care to children can prove extremely challenging and a lengthy process.

Paediatric nurses need to be aware of how children cope with painful and traumatic experience depending on their cognitive ability and stage of development. Patience and empathy are key skills for paediatric nurses recognising that the child may be scared and stressed as they may not fully understand why the procedure needs to be performed. It has been known for nurses to encourage patients from under tables for treatment to be carried out. Therefore, the ability to communicate with children at their level is vital to ensure the child understands what is happening to gain their trust. Different communication strategies, recognition of non-verbal cues, and active listening are fundamental to effective care. Nurses not only need to ensure the voice of the child is heard, but to be their advocate when the child has no voice.

We also need to be able to communicate with distressed and anxious parents/carers ensuring that they have key information to make informed choices for their child.

Using appropriate distraction techniques, and involving Play Specialist, can contribute to creating an environment where the child, and parent, feel safe while improving compliance.

GG: The experience of a paediatric trained nurse in relation to communication and supporting a baby or child and their families would hopefully improve the outcomes and have a greater positive impact compared with non-paediatric trained. The basic understanding of the anatomy and physiology of the paediatric population will be beneficial. However, if the TVN accesses and uses appropriate research, resources and training and they work collaboratively this should minimise potential problems. As stated in the Best Practice Statement (2014) paediatric patients have special psychosocial needs, and their parents/guardians may react differently to the child's care than they would their own, by considering the whole child, not simply the wound being treated, as well as the experience of the child and family when integrating and coordinating care and services. Whether this is met by a specialist paediatric nurse or not the principles should be applied to each individual.

As a non-paeds TVN I have recently joined the UK Paediatric Tissue Viability Nurses Group with one of my paediatric colleagues and we are hoping to both increase our knowledge and skills in caring for children in our care with wounds.

LR: Visits to children in my team are carried out in the presence of a registered children's nurse because of my lack of paediatric knowledge.

Levels of communication — Patient versus Parent. Communication with the child's parent is second nature as an adult nurse. What is difficult is ascertaining at what level to communicate with the child. Often the children's nurse will have had previous input and will have developed a therapeutic relationship with the family and so has prior understanding into the child's emotional, psychological and social development, how best to relay information and at what level to pitch this.

Sepsis in children presents differently than in adults, with the symptoms being more subtle, and deterioration occurring more rapidly due to having less physical reserve than adults typically have. There is a reliance on paediatric assessment and intuition, which the adult nurse may not have if they do not regularly care for children, thus important indicators in a sick child could be missed. I am reliant on the accompanying children's nurse to provide physical and behavioural assessments outside of the initial wound assessment. I as a clinician cannot meet my goal of holistic care without assistance in the same way as I might in an adult.

3. Do you believe a more family centred approach is required with this population?

CG: Absolutely. The ethos of family centred care is integral to paediatric nursing as the needs of the child are considered within the family, with the parents seen as the primary carers.

Having an understanding of the family

unit as a whole supports consideration of changing family dynamics, recognition of the family strengths, and incorporating the family views, enabling the nurse to have the child at the centre of care. It also facilitates an understanding of family beliefs, cultural values and their coping strategies.

By building relationships based on openness, honesty, respect and trust; empowering families through education and training to develop their skills and confidence, as well as negotiating roles and treatment plans, facilitates parent professional collaboration to ensure effective partnership working.

Parents are attuned to their child's needs and by including them in the decision making process, seamless care can be provided, incorporating the child and family's needs while ensuring practice is safe and effective.

For paediatric nurse's family centred care is pivotal to ensure that care is responsive to the child and family needs to achieve best outcomes.

GG: Yes. I think a family centred collaborative approach is absolutely essential. We must engage with the families, they are the ones living and dealing with a child/baby with a wound around the clock, the professionals, especially when in community, are present for very short windows of time. We need to ensure the families have the skills and confidence to cope in our absence and to have faith in the professionals that they are supported, listened to and understood. We must be advocates for them and the child, speak on their behalf if necessary but ultimately be guided by the family.

FD: Children's nurses in my Trust work between acute and community services so will have often already forged therapeutic and trusting relationships with the child and their family prior to discharge home.

I feel that paediatric nursing is already very family centred, this perhaps even being considered the overarching ethos of the speciality — the child relies on their parent or guardian to gather, assimilate and use the information given to them in order to make decisions in the best interests of their child.

This is sometimes daunting when you are used to delivering information, collaborating on treatment plans and seeking consent directly from the patient in adult nursing. With children, I find it important to remember that I have been tasked with formulating the care of the most important person in this adult's life. The parent knows their child best so it is important to listen, offer clear information while recognising boundaries and avoid overstepping.

Parents regularly assume responsibility for monitoring of the child's skin and dressing procedures, with the children's nurse supporting the parent and offering periodic supervisory visits. This differs in adult nursing where the nurse will undertake these procedures and there has been less of an emphasis on 'self-care' until fairly recently. This surprised me when first caring for children in my role. Perhaps this is because of the weight given to accountability in adult nursing particularly surrounding skin inspection, risk assessment, care delivery and avoiding omissions in care concerning tissue viability.

4. What are the most challenging aspects of paediatric wound care?

CG: Within this population compliance and concordance issues can be problematic.

Availability of dressing sizes suitable for the paediatric population remains challenging. On occasion nurses still need to tailor dressings to accommodate smaller wound sizes, i.e. dehiscence surgical wounds in neonatal population. This can result in the dressing being less effective.

Wound dressing selection is also limited due to products not being licenced for children, having age limitations and contraindicated due to children's physiology as well as disease process. Therefore, there is a need to work in collaboration with industry partners to devise products specific for paediatrics.

Further challenges is the availability of paediatric pressure ulcer prevention and management strategies with a limited selection of pressure relieving equipment suitable due to patients size and weight restrictions.

Research in paediatric care is sparse due to ethical issues in obtaining informed consent from children, therefore standardised and evidence-based practice can be challenging. Wound conferences and study days are targeted towards the adult population. Thus, there is a need to incorporate more education and training relating to paediatric wound care.

Furthermore, the lack of Paediatric TVNs across the UK in comparison to their adult counterparts hinders the development of robust support network.

GG: As a non-paediatric trained TVN working very closely with my paediatric colleagues I find communicating with the child and understanding their experience and ability to describe what they are feeling very challenging. I rely very heavily on my colleagues to support with this, using their experience to guide me, and obviously the family/carers of the child if the child themselves are unable to communicate us. I think wound care in general requires a lot of out of the box thinking, to find solutions for problems where there is no defined answer, this is even more true in caring for children.

So often in wound care things need to be adapted to get the desired outcomes, and when managing wounds and children this is key. You cannot always explain to a child or baby that they have to leave a dressing alone, so innovative ideas to protect the dressing, the wound and the child is the way forward, though this may not always be in line with recognised methods and may raise a few eyebrows, that must be preferable to further damage, pain or distress.

LR: Communication with the child's parent is second nature as an adult nurse. What is difficult is ascertaining at what level to communicate with the child. Often the children's nurse will have had previous input and will have developed a therapeutic relationship with the family and so has prior understanding in how best to relay information and at what level to pitch this. My team struggles to offer a regular and targeted programme of education to meet the needs of children's nurses due to this. We instead rely on the circulation of specific paediatric or other potentially relevant virtual training or undertake opportunistic training during patient visits to upskill staff.

The lack of products licensed for paediatric use. I usually try to keep things simple, gentle and where possible natural (skin care and using surfactants with dressings such as alginogel, honey and alginates) with younger patients for fear of causing pain or due to potential harm from over absorption of active ingredients i.e. silver, iodine etc.

Product sizing can make life interesting; there are a lack of small sizes for children. I usually use "lite" foam dressings or bandaging due to size ranges, I sometimes have to adapt or modify dressings to fit the need. I have become quite adept at using component parts to 'manufacture' dressings, for example, silicone foams and tapes to create the correct size 'foam adhesive'. WUK