Managing children with health care needs: delegation of clinical procedures, training and accountability issues

Background

In 2004 the Council for Disabled Children published 'the Dignity of Risk'[1] which contained an advisory list of procedures previously produced by the Royal College of Nursing in 1999, highlighting those clinical procedures which could be safely taught and delegated to non-health qualified staff. This list was subsequently updated for 'Including Me' in 2005[2]. Further revisions have since been made to reflect some of the queries which have arisen, clarifying pointers as needed. This document will continue to be updated at periodic intervals.

Clinical procedures which might be undertaken by non-health qualified staff

Administration of medication or invasive clinical procedures should only be undertaken by staff or carers when prescribed by a qualified nurse*, qualified medical practitioner or qualified dentist. Staff and carers should only agree to undertake these tasks if they feel competent and confident to do so.

In order to safely and effectively support the care needs of children requiring these procedures comprehensive training needs to be in place and delivered by appropriately qualified nursing staff.

Underpinning principles

- The training programme must be designed to enable carers to
    - care for a child who is medically stable
    - recognise signs of when the child is becoming unwell
    - Know how to seek appropriate help[3].

  NB. If the child becomes unwell they need to be seen by appropriate clinical staff and cared for by appropriately qualified staff (Registered nursing care may be required at such times).
- Non-health qualified staff should be trained to deliver care according to set protocols and guidelines and would not be expected to make independent decisions about a child's care, but refer these to either a parent or health professional.

* In respect of medications – only nurses who have completed the required training as a non-medical prescriber can prescribe medications

The permitted tasks for non-health qualified staff and focus of training for these tasks must be on the care as it applies to a **named** child. The individual carer will require specific training and assessment in order to participate in the care of a second or third child.

The following advisory list of procedures may be safely taught and delegated to non-health qualified staff following a child-specific assessment of clinical risk:

- Administering medicine in accordance with prescribed medicine in pre-measured dose via nasogastric tube, gastrostomy tube, or orally
- Bolus or continuous feeds via a nasogastric tube
- Bolus or continuous feeds using a pump via a gastrostomy tube
- Tracheostomy care including suction using a suction catheter
- Emergency change of tracheostomy tube[†]
- Oral suction with a yanker sucker
- Injections (intramuscular or subcutaneous). These may be single dose or multiple dose devices which are pre-assembled with pre-determined amounts of medication to be administered as documented in the individual child's care plan (preloaded devices should be marked when to be administered e.g. for diabetes where the dose might be different am or pm. In many circumstances there may be two different pens, one with short-acting insulin to be administered at specified times during the day and another for administration at night with long acting insulin).
- Intermittent catheterisation and catheter care
- Care of Mitrofanoff
- Stoma care including maintenance of patency of a stoma in an emergency situation using for example the tip of a soft foley catheter and replacement of button devises once stoma has been well established for more than 6 months and there have been no problems with the stoma[‡].
- Inserting suppositories or pessaries with a pre-packaged dose of a prescribed medicine
- Rectal medication with a pre-packaged dose i.e. rectal diazepam

[†] Routine tracheostomy changes provide an opportunity for a registered practitioner to assess carer competency while also undertaking an assessment of the tracheostomy site

[‡] The first time replacement must be undertaken by an appropriately qualified nurse or qualified medical practitioner.

- Rectal paraldehyde which is not pre-packaged and has to be prepared – permitted on a named child basis as agreed by the child's lead medical practitioner i.e. GP or paediatrician
- Manual Evacuation
- Administration of buccal or intra-nasal Midazolam and Hypo stat or GlucoGel.
- Emergency treatments covered in basic first aid training including airway management
- Assistance with inhalers, cartridges and nebulisers
- Assistance with prescribed oxygen administration including oxygen saturation monitoring where required
- Administration and care of liquid oxygen administration including filling of portable liquid oxygen cylinder from main tank
- Blood Glucose monitoring as agreed by the child's lead nursing/medical practitioner i.e. GP, paediatrician or paediatric diabetes nurse specialist
- Ventilation care for a child with a predictable medical condition and stable ventilation requirements (both invasive and non-invasive ventilation). NB. Stability of ventilation requirements should be determined by the child's respiratory physician and will include consideration of the predictability of the child's ventilation needs to enable the key tasks to be clearly learnt.

The following tasks should **not** be undertaken by non-health qualified carers:

- Assessment of care needs, planning a programme of care or evaluating outcomes of a programme of care
- Re-insertion of nasogastric tube
- Re-insertion of PEG's or other gastrostomy tubes
- Intramuscular and sub-cutaneous injections involving assembling syringe or intravenous, administration
- Programming of syringe drivers
- Filling of oxygen cylinders (other than liquid oxygen as stated above)
- Deep Suctioning (oral suctioning tube beyond back of mouth or tracheal suctioning beyond the end of the trachae tube)
- Siting of indwelling catheters
- Medicine not prescribed or included in the care plan
- Ventilation care for an unstable and unpredictable child

Delegation and accountability

Nursing involves complex tasks and procedures and even though health care support staff may have been trained to provide certain aspects of care to specific children, they may not necessarily be competent in all circumstances to do so. The NMC code states:

4.6 You remain accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it and that adequate supervision and support is provided.

When delegating any aspect of care the NMC states that each child should be clinically assessed and the most appropriate person appointed to deliver any subsequent care. If this is a health care support worker then the registered nurse delegating the care should ensure they are competent to undertake the task being requested of them. The NMC advises that if a registrant feels they have been asked to delegate care to a health care support worker who they believe does not have the required competency or it is an inappropriate delegation, then they should refuse the instruction. This should then be raised formally with their employers including the justification for taking such a decision. Clause 8.2 and 8.3 of the Code supports this:

8.2 You must act quickly to protect patients and clients from risk if you have good reason to believe that you or a colleague, from your own or another profession, may not be fit to practice for reasons of conduct, health or competence

8.3 Where you cannot remedy circumstances in the environment of care that could jeopardise standards of practice, you must report them to a senior person with sufficient authority to manage them and also, in the case of midwifery, to the supervisor of midwives. This must be supported by a written record.

When a registered nurse assesses a member of health care support staff to carry out an aspect of care, then that must also include all aspects of the task including recording activities completed in the child's record. The best interests of the child are paramount. It is important that in order to promote this registrants must ensure that they provide appropriate support and supervision to health care support staff when performing delegated care delivery.

Any delegation of clinical tasks to non-health qualified staff must be undertaken within a robust governance framework which encompasses:

- Initial training and preparation
- Assessment and confirmation of competence
- Confirmation of arrangements for on-going support, updating of training and reassessment of competence

Training non health qualified staff

The aim of a training programme should be to provide information and learning about both theoretical and practical aspects of the carers role. Opportunities must be provided for supervised practice before an assessment of competence by a suitably qualified person[§]. This process should take into account the views of the child or young person, parents and the views of the person being assessed.

Training should take place at two levels:

- General training around complex health needs
- Training around a specific child and the procedures or the care that child will require

Key elements of a training programme are suggested as follows

- A competency-based approach
- Written goals for individuals
- Audit cycles (regular updating and reassessing of competence)
- Evaluation criteria
- Statements of accountability
- Confidentiality
- The care of the required equipment
- Care of the child's holistic care needs including social and developmental care
- Emergency management
- Risk assessment and when to get help

In the same way as information is shared on a need-to-know basis, training should be arranged on a general level for all staff working with a particular child and specific training for staff who will be supporting a child on a one-to-one basis.

The trainee must be assessed as competent to undertake the task and documentation signed by the health care professional to indicate this. At the time of

[§] This is usually an appropriately qualified nurse such as a Community Children's Nurse

assessment of competence the monitoring and date of training update will be agreed and recorded.

An example of general and specific training around complex health needs including core competencies for training that can then be used locally with necessary adaptations alongside standardising policies and procedures will be added in due course.

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References

[1] Council for Disabled Children, Shared Care Network and National Children's Bureau (2004) The Dignity of Risk, London: National Children's Bureau, Council for Disabled Children and Shared Care Network
[2] Council for Disabled Children, Department for Education and Skills (2005) Including Me, London: Council for Disabled Children
[3] Noyes, J and Lewis, M (2005) From Hospital to Home. Guidance on the discharge management and community support for children using long-term ventilation, Essex, Barnardos.
4. NMC (2007) Advice on delegation for NMC registrants, London: NMC