

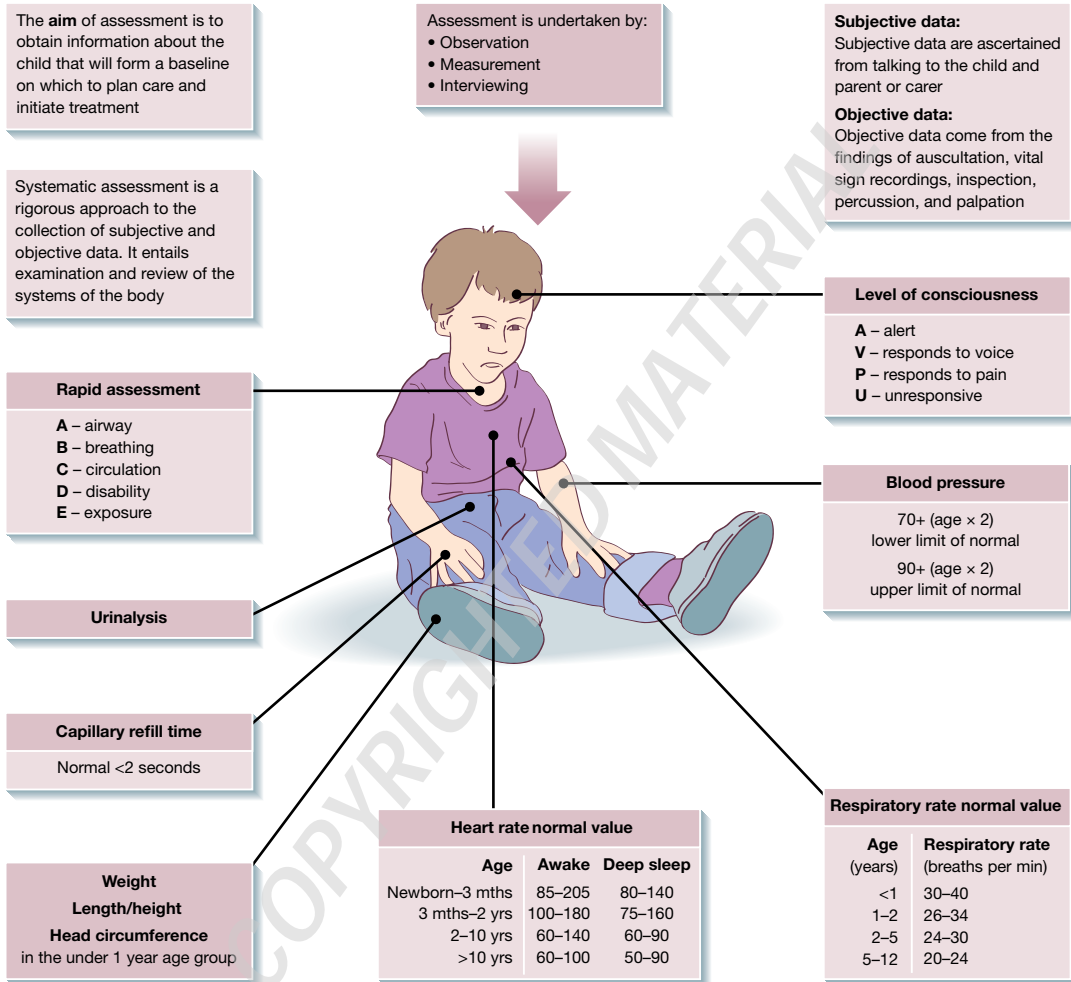
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Assessment of the child and young person

Figure 1.1 Assessment of the child and young person.

Assessment is the gathering of information and formulation of judgements in partnership with the child and family. It is a continuous, dynamic process and includes the physiological, physical, psychological, social, and spiritual aspects of the child and the effect that their health problem is having on their development and family life. Accurate assessment of the infant or child is essential to the delivery of safe and effective care. Depending on the child's presenting condition, a focused assessment may be required in the case of the seriously ill child, necessitating prioritization of care until the child's condition is stable.

Assessment leads to the identification of health problems and the development of care plans.



Box 1.1 HEADSSS tool

HEADSSS is an interview prompt tool used specifically to assess the health needs of young people. It may be used as a self-assessment tool as well as by healthcare professionals. It has been successful in identifying concerns that require further interventions. The acronym stands for:

- H – home
- E – education and employment
- A – activities
- D – drugs/drink
- S – sex
- S – self-harm, depression, and suicide
- S – safety (relationships, online)

Key points

- Use a recognized framework when assessing the child or young person, as this will enable a systematic and thorough approach.
- Assessment is an ongoing process and will take place at many points in the child's or young person's clinical journey.
- Age- and development-appropriate questions and tools should be used.

Introduction

Assessment is a key component of nursing practice and is required for planning and implementing child- and family-centred care (Figure 1.1). Registered nurses must be proficient in assessment at the point of registration. They need to be able to prioritize the physical, social, behavioural, cognitive, spiritual, and mental health needs of the child/young person. Partnership working with the child and family is required as their needs and preferences must be given due regard. The nurse needs to utilize this information when prioritizing and planning child-centred evidence-based care to meet the patient's needs. Assessment is the collection of data, both subjective and objective, which aims to achieve a complete picture of the child's health status. Good assessment is a combination of the interpretation of physical data and the information gained from observation of the child and family and from listening to them. Assessment tools may be used for aspects of the assessment, such as pain, nutrition, or wound assessment.

Interviewing – history taking

Gaining the trust of the child and family is an essential element in developing an effective therapeutic relationship. Introducing yourself to the child and family with explanations of expected outcomes will put the child and family at ease. Age-appropriate language should be used. Questions should be directed at both the child and the parent. Young people should have an opportunity to talk in private if they wish and the HEADSSS tool is commonly used when history taking in this age group (Box 1.1).

When taking a history, a structured approach should be used. This needs to include:

- Presenting complaint.
- History of presenting complaint.
- Past medical history (birth and neonatal history in infants and young children), immunizations, illnesses, and hospitalizations.
- Allergies.
- Current medication.
- Developmental history.
- Family history.
- Social history – nursery, school, HEADSSS tool.

Observation – subjective data

Subjective data are what the child and parent say along with the visual information gained from the initial encounter with the child and family or while obtaining objective data (physical examination and recording of vital signs). This includes noting:

- Their colour: are they pale, mottled, cyanosed, jaundiced, flushed.
- Behaviour: alert, crying, agitated, combative, lethargic, drowsy, distressed.
- Mental health and wellbeing status, HEADSSS assessment for young people (Box 1.1).
- Interaction with parents/carers/strangers.
- Interaction with environment, wanting to play or sleepy.
- Position: normal, floppy, or stiff.
- The general appearance of the child, e.g. unkempt or clean.
- Obvious birthmarks, bruises, or rashes.
- Dysmorphic features.

Measuring – objective data

All infants, children, and young people require a baseline physical assessment. This is a multifaceted process and some aspects are common to all children who require assessment of their health status. The physical assessment is concerned with the analysis and interpretation of data. Privacy and dignity should be maintained

during this process. Consent should be obtained prior to undertaking a physical assessment.

Physical assessment includes:

- Basic physical recordings of temperature, pulse rate, respiratory rate, oxygen saturation, and blood pressure.
- Respiratory assessment, rate of breathing, depth of breathing, noise of breathing, presence of cough, chest movement, nasal flaring, use of other accessory muscles, child's colour, ability to speak/feed, position of the child, peak flow, and oxygen saturation level.
- Heart rate including pulse volume.
- Capillary refill time.
- Neurological status using Glasgow Coma Scale or AVPU (Alert, Voice, Pain, Unresponsive).
- Level of hydration: obvious signs of dehydration include sunken anterior fontanelle, dull sunken eyes, dry oral mucosa, lethargy, weak cry, decreased urinary output.
- Weight.
- Height/length.
- Head circumference.
- Skin assessment using recognized pressure risk assessment tool.
- Urinalysis.
- Blood glucose if required.

All findings need to be documented, as they are a legal record of the nursing assessment, the foundation on which care is planned and the basis of communication with the multidisciplinary team. A more focused nursing assessment may be required of a specific body system relating to the presenting problem or other concerns noted. This may be uni- or multisystem. Clinical judgement will determine where the focus of assessment will be.

Approach to assessment

The approach taken to assessment will impact on the success and ease of actually undertaking the physical assessment. The children's nurse should consider the following:

- Age and development stage of the child.
- Undertaking examination of the least intrusive areas first and painful, sensitive areas last.
- Their own behaviour and showing respect for the child's culture and personal preference.
- Clustering their assessment with other areas of care so as to avoid unnecessary disruption, but also being aware of the clinical needs of the child against their need to rest.
- Identifying what parts of the assessment should be carried out before the child is likely to become upset and cry, e.g. chest auscultation, heart sounds.
- Encouraging the child and family to voice any concerns or questions.

Evaluation

Evaluation requires the children's nurse to ensure the correct information has been collected, and that it is accurate and documented. Abnormal findings should be acted on straightaway. The children's nurse will need to process the information, both objective and subjective, and utilize this to draw on their problem-solving and critical thinking skills to plan person-centred, evidence-based nursing interventions.

Summary

Assessment is a dynamic, continuous process that needs to include the child's and parent or caregiver's perspectives. Evidence-based and best practice approaches should always be used when assessing the child or young person. Observation is as essential as physical assessment, and good communication skills are important too.