Who’s who?

There are many different people on the children’s ward, some of whom have jobs unique to dealing with children. This can be a little daunting at first if you’re not sure what they all do and means that you have a lot of names to learn. However, having such a large and varied team means that collectively, you can provide much better care for your patients and their families and you can learn a lot from your colleagues’ expertise. Understanding a little bit about what everyone in the team does will allow you to make the best use of their skills. The list below gives a brief description of some of the roles within the team. They are listed in alphabetical order for ease of reference.

Breastfeeding advisor

Many breastfeeding supporters are mothers who have trained to provide breastfeeding advice on a voluntary basis. They have a wealth of knowledge and tips and are able to provide support to mothers who are having difficulty establishing breastfeeding.

Child protection nurse

By law, each hospital or community trust must have a named nurse and a named doctor who are responsible for child protection. Child protection nurses are extremely knowledgeable and are a very useful first port of call for advice if you have any concerns about a child’s welfare. They attend child protection and psychosocial meetings and will often provide training on child protection to other members of staff.

Clinical support worker

Sometimes also known as therapy helper or therapy assistant. Their role is to work alongside, and under the supervision of, allied health professionals (such as physiotherapists and occupational therapists) and help with therapy sessions by preparing equipment, getting the patient ready before the session and providing an extra pair of hands during therapy sessions.

Dietitian

The dietitian can give advice on feeding and nutrition, including advising about parenteral nutrition regimes or dietary supplements. They are crucial in the
management of patients with eating disorders and can advise on monitoring for refeeding syndrome. They can also provide advice to children with food allergies.

**Health visitor**

Health visitors work in the community but you may come across them in the hospital at psychosocial meetings or when you are working in community paediatrics. Their work is varied but mostly involves going to visit families in their own homes. Health visitors routinely visit all new parents to provide any necessary advice or support in caring for their new baby. During these first few visits, they assess the level of support the parents need and decide how much longer they need to continue working with that family or if they need to refer on to other specialist services. They also play a vital role in supporting vulnerable children and families and are trained in recognising signs of abuse and neglect in children. They may be the first to raise concerns about the welfare of a child due to the valuable insight they gain from visiting families in their own homes.

**Healthcare assistant**

This is often abbreviated to HCA and HCAs are sometimes also known as auxiliary nurses or nurse auxiliaries. Their role is to work alongside nurses and midwives to provide them with support in their work. They will always be working under the supervision of a registered nurse or midwife. Duties involve things like helping with washing and dressing, meals, making beds and taking observations. The experience of healthcare assistants can vary a lot. Some may be working as a HCA whilst studying to become a registered nurse whilst others may have little or no medical knowledge. It is important to understand that the role and training level of healthcare assistants differ significantly from those of nurses (they are unable to dispense medications, for example).

**Midwife**

Midwives have a varied role as they are involved in the care of pregnant women antenatally, the safety of mother and baby during labour and delivery, and the care of mother and baby in the early postnatal period. They are able to offer advice to mothers about feeding, supported by the breastfeeding advisor for women who need additional support. Some midwives are also trained to perform newborn baby checks.

**Nursery assistant**

Nursery assistants need no specific childcare qualifications but will assist nursery nurses in their work and under supervision. They can still provide very useful support to children by engaging them in play and distracting them from procedures but will not be able to help with more specialist work such as explaining diagnoses through play in the same way as a play specialist or nursery nurse would be able to.
Nursery nurse

Nursery nurses have many similar roles to the hospital play specialists but will often also work in community settings. In order to be a nursery nurse, they will have a childcare qualification but will not have trained to as high a level as a play specialist (who undergoes additional training). They may work alongside play specialists.

Occupational therapist

The role of the occupational therapist (also called an OT) is to help children to be able to do all the things that any child of their age could do. Essentially, their role involves assessing any physical or psychiatric IMPAIRMENT that the child may have and providing practical solutions to minimise the extent to which this impairment becomes a DISABILITY. This might mean making adaptations to the child’s home or providing them with equipment or tools to help them to complete tasks.

Orthoptist

Orthoptists work within the ophthalmology team to help diagnose, investigate and treat problems with eye movements, such as squints (strabismus). Some are also involved in vision screening for children in community health centres and schools.

Pharmacist

The ward pharmacist is an enormously useful source of information so make good use of them. They will be able to advise you on the latest research on certain medications, the most effective preparations to use and possible side-effects to be aware of, and can help you with difficult prescriptions. They also check all the drug charts and may spot mistakes you have made in your prescriptions. Try not to take this as a criticism but instead be grateful that they have pointed it out to you so that you have the chance to correct it and try to learn from their advice. They are also very useful for communicating with families and GPs to establish exactly which regular medications a child takes and to discuss changes to medications with parents.

Pharmacy technician

Pharmacy technicians work closely with pharmacists to assemble, label and dispense medications. They check the stock of medications on the ward and expiry dates of medications. They are sometimes also involved in checking and recording the medications patients are taking and talking with families about how to use their medicines safely at home. They may not have the same depth of knowledge as pharmacists for helping with queries about prescriptions.

Physician assistant

Only present in a handful of paediatric centres but an incredibly valuable resource (count yourself very lucky if you have them at your hospital). They are trained to support doctors in the medical management of patients and
can often perform blood tests and insert cannulas, check blood results, write discharge summaries and order investigations. As they take on some similar roles to junior doctors (but tend to be in the same post for longer), they become experts on the ins and outs of how the hospital works and can be vital to the smooth running of the department. There will be individual variation between what they are trained and comfortable doing so avoid making assumptions and ask.

Physiotherapist

Physiotherapists are highly trained and probably have a much better knowledge of working anatomy than you do. Physiotherapists help children with balance and mobility problems through exercises, manual therapy and provision of mobility aids (such as frames or wheelchairs). They can help with postural problems for children with spinal deformity, prevent joint contractures and also provide chest physiotherapy (for example, to help children with pneumonia to clear mucus from their airways).

Play specialist

Play specialists are experts in child development and age-appropriate play and will have had to study for several different qualifications (including a degree) in order to work as a hospital play specialist. They are crucial in helping to distract children whilst you are performing procedures and can help with the explanation of diagnoses and treatments to children through engaging them in play. They can also provide support to siblings and contribute to clinical decisions based on the child’s behaviour that they have observed whilst playing.

Psychologist

Child psychologists may specialise in either clinical or educational psychology. A clinical psychologist will be involved in the management of children with mental health problems such as anxiety and depression, those struggling to adjust to their physical illness or children with behavioural problems or issues with family relationships. Educational psychologists are more likely to work in a community setting. They aim to enhance the child’s learning ability through helping them with their emotional problems or learning difficulties and have an important role in advising teachers, parents and social workers.

School teacher

Many children’s departments will have a hospital school with a qualified teacher so that children do not fall behind with their education whilst they are inpatients. Teachers at hospital schools can be very helpful as part of the multidisciplinary team in identifying any ongoing special educational needs that the child may have. Some hospital schools have status as 'special schools' and teach children who are not currently inpatients but are not able to attend their normal school for medical reasons.
Specialist nurse

These are nurses who have specialised in a particular disease area and work solely with children and families with those diagnoses (for example, diabetes, cancer or sickle cell specialist nurses). They are incredibly knowledgeable in their area of expertise and are often involved in providing training to other healthcare staff, including doctors, on their specialist subject. They work closely with patients and families and can provide great continuity of care as they get to know their patients very well. Make sure that you inform them if a patient who is known to them is admitted so that they can come to review and offer advice. They are also enormously helpful in providing support to families whose child has been given a new diagnosis. Some specialist nurses may be independent practitioners who can manage children independently and prescribe medications.

Social worker

They provide support to vulnerable children and families in the community and also assess if a child is at risk of suffering abuse or neglect. They work closely with the multidisciplinary team in providing advice about children and families they are working with and attend regular psychosocial meetings at the hospital and in community settings as well as case conferences and child protection meetings. Good communication between social workers and hospital teams is crucial for managing child protection cases well. If you have concerns about the welfare of a child you can call the Child and Family social care team to ask for advice or make a formal referral. For more details see Chapter 4, Child Protection and Safeguarding. Social workers also have an important role in supporting children who have mental health problems such as those who are self-harming.

Speech and language therapist

Although speech and language therapists do have an important role to play in helping children who have difficulties developing speech (making the noise) and language (knowing the words), they do much more than this. They help children more broadly with communication, using communication aids such as symbol boards and voice synthesizers in order to help children who are having difficulties communicating. They are also crucial in helping with feeding issues, which isn’t totally obvious from their job title but makes sense when you think about it. They are experts on all things to do with the physical process of producing speech – mouth, tongue, larynx, etc. – and so, given that they already know so much about this, the natural extension is for them to be involved with things like swallowing which involves much of the same anatomy.

Staff nurse

New nurses who are studying now are all trained to degree level and paediatric nurses tend to be particularly motivated and skilled individuals. Getting on
getting started

well with the nursing staff is vital if you are going to provide good care for your patients as you will work more closely with them on a day-to-day basis than any other members of the multidisciplinary team.

Ward clerk

Ward clerks are responsible for requesting patient records and making sure that they are returned for storage after they have been used. They will file notes and chase up reports as well as answering phone calls and welcoming patients and families at a reception desk to the ward. They are likely to be able to book follow-up appointments for your patients, which can be really helpful for families to know as they leave rather than waiting for a letter. They can also track down missing notes for you and order stationery (such as replacement paper for the printer).

Ward sister

Ward sisters are senior and experienced paediatric nurses who are in charge of the day-to-day running of the ward. They supervise the nurses and healthcare assistants on the ward in addition to having lots of paperwork to complete and fulfilling their normal nursing duties. They are very busy people and their job can be extremely stressful so try to be considerate and not bother them unnecessarily when they are in the middle of something and don’t take it personally if they are sometimes a little short with you when you do. They can be a great source of advice and support when you are learning so don’t be afraid to ask for their help.

What happens where?

As well as there being lots of different people on the ward there are also some rooms and special wards which are unique to paediatrics.

Playroom

Many paediatric wards will have a playroom and if you can’t find one of your patients, this is usually the best place to start looking. It is really important for children to have time to play and many hospitals will have well-equipped playrooms with activities organised by play specialists.

Teenage room

Teenagers are unlikely to want to sit in the play room with lots of young, excited children. Many wards offer separate rooms for teenagers with more age-appropriate video games and reading material.

Treatment room

Unlike for adults, for whom most procedures are done at the bedside, this is avoided if possible for children. Procedures are not done at the bedside for young children unless absolutely necessary because it is important that they feel that their bed is a safe
place. Children’s wards will therefore have treatment rooms where children are taken to have procedures done. They are often decorated to try to make them as welcoming as possible.

**School room**

It is important that children continue to learn whilst they are in hospital so that they don’t fall behind with their education and also to normalise the hospital experience as much as possible. For this reason, children’s departments may have dedicated school rooms with a qualified teacher to provide lessons for inpatients.

**Parents’ room**

Parents are encouraged to stay with their children whilst they are in hospital to make the whole experience less frightening (for both child and parent). Wards will often have a room for parents to sit, sometimes with basic facilities such as a kettle or a microwave.

**Sensory room**

Some wards will have a sensory room, with interesting lights and colours and soft padding on the floors. These are great for young children and those with learning difficulties to enjoy with their parents.

**Day care unit**

Most paediatric units will have a day care ward for children who only need to come in for treatment during the day time (for example, for antibiotics, a minor procedure or sedation and imaging) but can go home overnight. You may be asked to review children on the day unit or prescribe medications for them as part of your ward or on-call duties. Day units are sometimes also known as ‘ambulatory units’.

**Milk room**

Neonatal wards usually have a dedicated room for preparation and storage of milk. This can be making up formula feeds or thawing out frozen breastmilk for feeding the babies on the ward.

**Postnatal ward**

This is where mothers and babies who are well will go after delivery. You may be asked to review babies on the postnatal ward if midwives have concerns and this is where you usually go to perform newborn baby checks prior to discharge.

**Paediatric emergency department**

Many hospitals will have a separate area for children coming to the emergency department and separate paediatric resuscitation rooms. Make sure that you know how to access the paediatric emergency department at your hospital and whether paediatric resuscitations take place in a dedicated children’s area or in the main emergency department resuscitation area so that you know where to run to in the event of a crash call.
Be prepared

It can be useful to have some extra things with you when you’re on the paediatric ward or on call.

- **A small toy.** This just needs to be something colourful which will entertain a small child for a couple of minutes whilst you try to examine them. It doesn’t have to be anything big or flashy. Lots of people will attach a small keyring to their stethoscope in the shape of an animal. Often this can double up as something else useful (for example, getting a toy which lights up with a bright white light for looking in throats, or is a clock with a second hand). If you actually hand the toy to the child for them to hold (rather than just look at) then make sure to clean it thoroughly afterwards for infection control reasons.

- **Calculator.** Most people will have a calculator function on their phone but it is not always convenient to take your phone around with you on the ward. You may wish to invest in a miniature calculator to carry around with you.

- **Stethoscope.** Obviously you need one of these. It’s not necessary to get a paediatric stethoscope initially, adult ones will work just fine.

- **Pen torch.** For looking more closely at rashes, checking pupillary reactions, looking in the back of throats or entertaining small children (lighting up the torch and then pretending to blow it out and letting go of the button so it turns off is a great way of engaging young children who will really want to have a go themselves).

- **Watch with a second hand.** The problem with the bare below the elbow policy is that if you’re not wearing a watch, you can’t count respiratory and pulse rates. These are crucial parts of your assessment of any child so invest in either a fob watch with a second hand or a keyring with a watch on it that you can attach to your stethoscope.
Jargon Buster

Key: Each term that **LOOKS LIKE THIS** is a jargon buster!

**32 PLUS 3** This is just an example of the actual numbers used but when people talk about a baby who was born at ‘32 plus 3’, what they mean is that the baby was 32 (completed) weeks and 3 days gestation when he or she was born. This is often written as ‘32+3’ when it is recorded in the notes.

**5 IN 1** Single vaccine against five different diseases: diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b.

**ACHIEVING BEST EVIDENCE** This is the guidance set out for police officers about the best way of interviewing children about crimes that they have been victim of or witness to. It is about asking open, non-leading questions in order to gain the most reliable story from the child. This is important in cases of abuse when taking a history too as you want to avoid asking any leading questions in your history taking. If you have asked the child leading questions, it may mean that their statements will be judged as less reliable by the courts and could alter the outcome of a court case.

**ADLS** This stands for activities of daily living. It refers to all the things that we all do every day like washing, eating, dressing and going to the toilet.

**ALTE** This stands for apparently life-threatening event and is the term used to refer to reported episodes (usually in young babies) of the child becoming floppy, blue and unresponsive.

**BLOOD GAS** Do not assume when people talk about blood gases in pediatrics that they are referring to an arterial blood gas. These are rarely done in children and a venous or capillary blood gas is much more likely to be used instead. See Chapter 6 – Practical Procedures, for information on how to take a capillary blood gas sample.

**BODY MAP** A standard blank diagram of a child’s body on which you can draw any injuries or marks you have seen in the appropriate places. This makes it much easier to be accurate than trying to draw the child yourself or just using words to describe the size and location of marks. There are different body maps available for infants, older children and genitalia.

**BURST THERAPY** Giving three lots of salbutamol nebulisers and one lot of ipratropium nebulisers back to back to a child presenting with asthma.

**CAIT** If you hear people referring to ‘CAIT’ they may not be talking about a person called Kate, but about the Child Abuse Investigation Team! This is a specialised team of police officers who investigate possible criminal offences related to the abuse of children.

**CAF** You may hear people talking about ‘CAF’ forms. This stands for ‘Common Assessment Framework’. These are often used for communicating child protection concerns to social services in writing (usually following a phone conversation with them about the case).
CAFCASS  This stands for Child and Family Court Advisory and Support Service. This is an organisation which provides support and advice to families going through court proceedings. Their social workers act as advocates for children and help to advise the courts as to what is in that child’s best interests. Their website (www.cafcass.gov.uk) has lots of information written specifically for children, teenagers and families about the support that CAFCASS provides and the processes involved in court proceedings.

CAMHS  You may hear people referring to ‘cams’. This stands for ‘Child and Adolescent Mental Health Services’.

CAPILLARY REFILL TIME  This is often abbreviated to CRT. It is a way of assessing any problems with the child’s circulation by looking at skin perfusion. It is best measured centrally (usually over the sternum) as the peripheral measurement can vary depending on the room temperature. Press down for 5 sec and then remove your finger and count how long it takes for the skin to return to a normal colour. Anything less than 2 sec is normal.

CENTILES  The lines on growth charts which document the range of normal growth for children. If a child’s height is on the 98th centile, this means that only 2% of children this age will be taller.

CHAIN OF EVIDENCE  If you take a sample, the result of which may end up being used as evidence in court, you must use the chain of evidence process for that sample. For example, if you suspect a sexually transmitted infection in a young child, the result of any swabs you take may subsequently be used to convict someone of sexual abuse. This means that it must be clear that this is the right result for the right patient. For more about the chain of evidence process, see Chapter 4 under the Sexual abuse subheading.

CHILD IN NEED  A child in need is any child who will need input from services in order to reach or maintain a good standard of health and development. This means that all children with disabilities and looked-after children are automatically defined as children in need. A child who is at significant risk of abuse or neglect is also a child in need. For more about the child protection process, see Chapter 4 under Working with social services, education and the police.

CHILD PROTECTION CONFERENCE  This is a formal meeting that forms part of the assessment process if there are concerns that a child is subject to abuse or neglect. The meeting involves family members (including the child if appropriate), with any relevant supporters, advocates or professionals who have been involved with the child or the family. The purpose of the meeting is to decide if the child is at risk of significant harm in the future and therefore should be subject to a CHILD PROTECTION PLAN. For more about the child protection process, see Chapter 4 under Working with social services, education and the police.

CHILD PROTECTION PLAN  This is a plan put in place for children who
have been abused or neglected and who are at ongoing risk of harm. The plan outlines what needs to be done and by whom in order to keep the child safe. The type of abuse to which the child was being subjected is recorded as part of the plan (i.e. physical, sexual, etc.) and a lead social worker will be allocated to be in charge of the case and ensure that all the plans are implemented. For more about the child protection process, see Chapter 4 under Working with social services, education and the police.

**CHILD PROTECTION REGISTER** The child protection register used to be a list kept by the local authority of all children who were felt to be at risk of significant abuse but these lists no longer exist. You may well still hear people referring to a child being ‘on the register’ but this is outdated terminology. What they probably mean is that the child is ‘subject to a CHILD PROTECTION PLAN’.

**COMPENSATED SHOCK** This expression tends to be used much more frequently in paediatrics than in adult medicine. Children have a greater physiological reserve than adults and so can compensate for shock very well for some time before rapidly deteriorating. Compensated shock means that the child is still managing to maintain perfusion of their vital organs but you need to intervene soon in order to prevent progression to DECOMPENSATED SHOCK. For more about shock and resuscitation of acutely unwell children, see Chapter 5 – Common Paediatric Emergencies.

**CORE ASSESSMENT** Sometimes also known as a section 47 enquiry, this is a detailed assessment led by social services in cases when a child is thought to be at risk of abuse or neglect. Social services work with police, health and education to gather information and conduct interviews with parents and the child. Health professionals may be asked to carry out detailed assessments of the child’s development. The social worker then makes a decision about whether or not to convene a CHILD PROTECTION CONFERENCE. For more about the child protection process, see Chapter 4 under Working with social services, education and the police.

**CORRECTED GESTATIONAL AGE (ABBREVIATED TO CGA)** Also sometimes known as ‘corrected uterine age’, this is used for babies who are born prematurely. To work it out, add the number of days old the child is to the gestation they were when they were born, e.g. a baby born at 32+3 (i.e. 32 weeks and 3 days) who is now 13 days old would have a CGA of 34+2. This is useful because how a baby behaves and likely medical issues and appropriate treatment will vary based on their gestational age rather than how long they have been out of the womb for; i.e. a 13-day-old TERM BABY will be vastly different from a 13-day-old baby born at 26 weeks’ gestation in terms of size, physiology and development.

**CRASH TROLLEY** This is a portable trolley that contains all the equipment needed to resuscitate a patient. It usually has separate drawers for airway, breathing and circulation with all the
necessary equipment for each of these, any emergency drugs that may be needed and a defibrillator. Find out where the crash trolley is in your workplace so that you know where to find it in a hurry. You should also be aware that there are usually separate crash trolleys for children with appropriately sized equipment and drug doses.

**Decerebrate Posturing** This indicates brainstem damage and may signal that a respiratory arrest is imminent. It is a rigid posture with the arms and legs both extended and internally rotated, the neck extended and the back arched. If this posturing was preceded by **Decorticate Posturing**, then it may indicate brain herniation (or ‘coning’) as a result of raised intracranial pressure. See Chapter 5 – Common Paediatric Emergencies and Fig. 5.15 for more details.

**Decorticate Posturing** This indicates damage to the higher functioning portions of the brain such as the cerebral cortex. It is a rigid posture in which the arms are flexed and the hands clenched in fists and the legs are extended and internally rotated. See Chapter 5 – Common Paediatric Emergencies and Fig. 5.15 for more details.

**Developmental Delay** This is when a child is much slower than expected for their age in acquiring certain skills. This can be specific to one particular area of development (for example, isolated delayed speech development) or a child can have ‘global developmental delay’, meaning that they are slow to develop in many different areas. For more on child development see Chapter 2 – Child Development.

**Disability** A limitation of what a child is able to do relative to other healthy children of their age, as a result of an impairment. The environment in which a child lives affects the extent to which their impairment becomes a disability. For example, a child who is a triple amputee may have excellent prostheses and not be limited at all in their activities (it is even possible to snowboard with prosthetic limbs) but a child with poor vision who does not have access to glasses could be very disabled because of this impairment. In developed countries, most poor vision is not considered a disability at all because use of glasses to correct it is widespread, but these individuals would have limited function without them.

**Dysmorphic** The term used to describe babies who have unusual facial features. Dysmorphic features tend to
occur as a group of unusual characteristics together as part of a genetic syndrome (such as flattened nasal bridge and a protruding tongue in children with Down syndrome).

**Emergency Protection Order (EPO)** These can be applied for urgently from the court in cases where there is concern that a child is in immediate danger. If the Emergency Protection Order is granted by the courts, it gives the local authority the right to remove the child from their home to a place of safety. The EPO lasts for 8 days, during which time the local authority has parental responsibility for the child and can give consent to medical treatment on the child’s behalf if necessary.

**Ex-prem** A baby or child who was born prematurely but now has a corrected gestation equivalent to a term baby or older.

**Failure to Thrive** This is when a baby or child does not gain weight or grow at the rate they would be expected to. This can mean slow weight gain, no weight gain or even weight loss. There are many diagnoses that can be responsible for failure to thrive or it may simply be a result of the child not receiving adequate nutrition.

**Female Genital Mutilation (commonly abbreviated to FGM)** A general term referring to any process involving removal or injury of the external female genitalia for non-medical reasons. It can involve anything from cutting or piercing the genital area to total removal of the clitoris and labia minora or surgical narrowing of the vaginal opening. It may be referred to by families as ‘cutting’ or ‘female circumcision’.

**Fraser Guidelines** A set of guidelines laid out by Lord Fraser to help doctors make decisions about when a child under 16 years old may be capable of giving consent for contraception or an abortion.

**Gillick Competence** The term used to refer to children under the age of 16 who are thought to be capable of consenting to treatment themselves (without the need for parental consent). In order for a child to be deemed ‘Gillick Competent’, they must be able to understand the facts about the treatment, understand the consequences of the treatment or of not having the treatment and be able to weigh up these factors in order to come to a reasoned decision. The name ‘Gillick Competence’ arose following a case of a mother, Victoria Gillick, who went to the courts to seek a ruling that doctors could not prescribe contraception for her daughters who were under 16 without her consent. The House of Lords ruled against Gillick and determined that a parent was not able to overrule medical decisions made by a young person if they were able to fully understand the treatment that was proposed and therefore give consent themselves.

**Global Developmental Delay** See ‘developmental delay’ above.
**GRID TRAINING** You might hear people talking about how they are applying for ‘the grid’ or ‘grid training’. This basically means that they are applying to train in a subspecialty of paediatrics. For more information about grid training, see Chapter 11 – Developing Your Career.

**GUEDELL AIRWAY** Also known as an oropharyngeal airway, this is a curved plastic tube which can be used to keep a child’s airway open if the child has reduced conscious level.

**HEEL PRICK** This is a way of taking blood from babies and toddlers by using a lancet to form a small cut in the skin, allowing you to collect drops of blood by squeezing and encouraging the cut to bleed. This is usually done on the fleshy part of the heel (hence the name). For more about blood sampling, see Chapter 6 – Practical Procedures.

**IMPAIRMENT** A physical, cognitive or sensory abnormality.

**INITIAL ASSESSMENT** This is also known as a section 17 investigation. When a social worker receives a referral from someone who is worried about the child’s welfare, they may decide that further investigation of the concern is needed. This is called an initial assessment. They will contact multiple different agencies (education, police, etc.) to gather information about the child’s social circumstances and may also contact the person who made the referral to find out more detail about their concerns. They will also conduct interviews with the child and their family. After they have completed their assessment, they will make a decision about whether or not that child is a **CHILD IN NEED**.

**ISAM** You might hear people referring to an ‘eye-sam’ baby. This is an abbreviation for infant of substance-abusing mother and refers to babies with neonatal abstinence syndrome (see Chapter 4). This is a terrible abbreviation so try to avoid using it yourself.

**JABS** An informal word used for immunisations.

**LOOKED-AFTER CHILD** A looked-after child is one for whom the local authority is responsible. This normally means that the local authority shares **PARENTAL RESPONSIBILITY** with the child’s parents and that the local authority are responsible for finding a suitable place for the child to live (usually, with suitable relative, in a care home or with a foster family).

**MAINTENANCE PLUS 5%** This refers to a child who is 5% dehydrated and needs IV fluid replacement above the normal maintenance amount. It is calculated using a special formula; see the section on replacement therapy in Chapter 7 for details. It does not mean that you simply calculate their maintenance fluid volume and then add an additional 5% to that volume – this is incorrect and a common mistake!

**MEMBERSHIP OR MRCPCH** These both refer to the same thing which is the process of passing several exams in order to be allowed to practise as a registrar in paediatrics. Successfully passing all the
exams gains you membership of the Royal College of Paediatrics and Child Health or MRCPCH for short. This is the qualification to say that you can practise as a paediatrician.

**MICROTAINERS** These are paediatric blood bottles which are much smaller than adult bottles and only need 1 mL of blood to fill them.

**NEONATE** A neonate is a baby who is less than 1 month old.

**NICU** Often pronounced ‘nickoo’, this stands for neonatal intensive care unit.

**NIPE** You may hear people talking about ‘ny-pea’ – they are referring to the Newborn and Infant Physical Examination Programme (NIPE) which includes software used to record the outcome of newborn baby checks.

**NPA** This stands for nasopharyngeal aspirate, a procedure that involves suctioning secretions from a baby’s or child’s nose into a specimen pot that is sent to the laboratory for analysis. Nasopharyngeal aspirates are used to determine the causative organism of a respiratory infection (most commonly respiratory syncytial virus).

**OOPE** When people are talking about an ‘oo-pee’, they are probably referring to an Out of Programme Experience. This is an opportunity to take time out of the paediatric programme to pursue other interests (such as research or working abroad) or for personal reasons (such as childcare or ill health).

**PARENTAL RESPONSIBILITY** This is a legal definition referring to someone who is responsible for making important decisions about a child’s life such as where they go to school, where they live and whether or not to undergo medical treatments. Married couples both automatically have parental responsibility and this remains even if the couple divorce. Unmarried mothers automatically have parental responsibility but unmarried fathers do not. Others, such as stepparents, adoptive parents or the local authority, can acquire parental responsibility following application through the courts. For more details about parental responsibility and consent, see Chapter 3 – Communication with Children and their Parents.

**PEWS** Often pronounced in the same way as a church bench rather than the letters spelled out. PEWS stands for Paediatric Early Warning Score. It is a way of efficiently communicating between members of the team how well or unwell a child is based on their observations. A PEWS score for a normal, healthy child is 0 (i.e. all their observations are within normal range). The higher the PEWS score, the more unwell the child. The maximum score is 6.

**PICU** Sometimes said as the individual letters, sometimes pronounced ‘pickoo’. This stands for paediatric intensive care unit.

**PREDUCTAL SATURATIONS** This refers to measuring the oxygen saturation levels in the right hand of newborn babies. This is because this reflects the ‘predital’ circulation, i.e. the blood pumped from the left side of the heart, before it
mixes with blood from the right side via the ductus arteriosus, which remains patent for a short time after birth. For this reason you would expect the oxygen saturation levels to be slightly higher if measured in the right hand rather than the left hand or the feet, as the brachiocephalic artery (which supplies the right arm) branches from the aorta before the ductus arteriosus.

**QIP** People sometimes pronounce this 'quip'. It stands for quality improvement project which is what it sounds like – a project to try to improve the quality of some aspect of care provided to patients or the efficiency with which the hospital runs. These can be very effectively lead by junior doctors. They are a bit like audits, but for cases where you’re not comparing practice to a known standard but coming up with a new solution to a problem. This can be much more exciting than completing an audit by giving you a chance to be innovative and have an impact on patient care.

**RED BOOK** Also known as a personal child health record. All parents are given a red book with their newborn baby. This is a parent-held health record for that child which contains growth charts, details of immunisations and developmental milestones, amongst other things. It can be filled in by healthcare professionals and parents.

**REGRESSION** If a child is described as ‘regressing’ this means that they have lost the ability to do things that they could previously do. This is very worrying as it can reflect a serious underlying neurodegenerative condition. It is normal for children to behave slightly younger than they normally would when they are unwell or frightened or following the birth of a new sibling but regression refers to a permanent loss of skills, not just a temporary change in behaviour:

**RESUSCITAIRE** Resuscitaires are the mini workstations/platforms with all the gadgetry you may need for resuscitating a newborn attached to them.

**SBAR** Often pronounced ‘ess-bar’, this is a structure to aid communication between team members. It stands for Situation, Background, Assessment and Recommendations. For more information about using SBAR, see Chapter 10 – Looking After Yourself.

**SBR** Stands for spun bilirubin, a quick way of getting a result for total bilirubin levels in a serum sample. Usually performed using machines on the ward by clinical staff (see Chapter 6 – Practical Procedures). If you send a sample to the laboratory you will get a breakdown of the conjugated and unconjugated fraction of bilirubin too.

**SCBU** Sometimes pronounced ‘skuh-boo’, this stands for special care baby unit. It is for neonates who still need to be in hospital but do not require as much intensive or specialist treatment as babies on the intensive care unit.

**SECTION 17 INVESTIGATION** See ‘initial assessment’.

**SECTION 47 INVESTIGATION** See ‘core assessment’.
SEE-SAW BREATHING  This is when a child is attempting to breathe against an obstructed or partially obstructed airway. This results in their abdomen moving out and their chest wall moving in as they attempt to breathe in. It is a worrying sign as it suggests airway obstruction.

SPA  This stands for suprapubic aspirate. This is a method of collecting a urine sample by using a needle to enter the bladder through the anterior abdominal wall. For more about how to do this procedure, see Chapter 6 – Practical Procedures.

STATEMENT OF SPECIAL EDUCATIONAL NEEDS  This is a document put together for a child with complex or severe difficulties following assessment by the local education authority. It details what the child’s educational needs are and what support they will need. It is reviewed annually.

STRATEGY DISCUSSION/STRATEGY MEETING  This is the step after an INITIAL ASSESSMENT in the child protection process. It can be in the form of a meeting or can be done with separate phone calls to each of the agencies by the social worker. As a minimum, it must involve a social worker and their manager; a police officer and a health professional but may include other relevant people such as the person who made the referral and teachers from the child’s school or nursery. This is used as a way of everyone sharing relevant information which allows decisions to be made about whether any immediate action is needed to keep the child safe, whether a CORE ASSESSMENT should take place and if and when any criminal investigation will take place.

STRETCHING  Stretching a child may sound like physiotherapy or a form of torture but in fact it relates to ‘stretching’ the time between nebulisers for children with asthma, e.g. ‘stretching’ from 2-hourly to 4-hourly nebulisers for a child whose wheeze seems to be improving.

SUPERVISED LEARNING EVENTS  Sometimes abbreviated to SLE. This is just a different expression sometimes used for work-based assessments (see below).

TERM BABY  Baby born at or after 37 weeks’ gestation.

TERTIARY CENTRE  You will probably be familiar with the terms primary and secondary care (referring to community-based and hospital-based care respectively). Tertiary care is the next level up. Tertiary centres provide super-specialist care which is not available at most hospitals. There are many fewer places which provide tertiary care, meaning that families sometimes have to travel quite long distances for these services.

WAFTING OXYGEN  In situations when a young child has a partially obstructed airway it is really important not to upset them as this can result in total occlusion of their airway. Ideally, you want to give high-flow oxygen to children with airway compromise but you also want to avoid upsetting young children who do not like having a mask fitted. In this situation, the child shouldn’t be forced to wear the mask but instead you can
ask their parent to hold the mask near to the child’s face in an attempt to slightly increase their inspired oxygen concentration. This is sometimes referred to as ‘wafting oxygen’.

**WORKPLACE-BASED ASSESSMENTS**  This is sometimes shortened to WBAs or WPBAs. These are not exams but formative assessments which you must complete on a regular basis at work in order to show how you are progressing. There are several different types of assessments but this is the umbrella term used for all of them. *For more about work-based assessments, see Chapter 11 – Developing Your Career.*