History Taking in Pediatrics

436 F notes in red
435 notes in blue

Dr Hani Temsah
Consultant Pediatric Intensivist,
PICU, KSUMC
Associate Professor of Pediatrics, KSU

Objectives / Outcomes

- To Have an Introduction to History Taking in Pediatrics
- To Highlight the Special Items in the Pediatric History as Compared to Adult

Books notes (illustrated and Kaplan)
Doctors notes
Important

Important in OSCE

Introductory information

What is different than adults when taking pediatrics hx?
-developmental hx + prenatal history
-feeding hx
-noanatal hx
-growth chart
-source of hx (you rely on someone else (parents) in taking the hx
-immunization (vaccination hx)
-the symptoms are a bit different (non specific

- Introduce yourself
- Establish rapport — To the patient and the family. So you are interviewing two here, not only one
- Name, age, gender (Patient ID) — You should have 2 identifiers (name and file number or name and date of birth.
- Person giving the history (parent, etc)

  - Reliability — Does the historian know about the child for example how much the baby has vomitted
- Origin — For genetic diseases

Establishing rapport with an infant is different than toddlers or adolescents so it depends on the age..
- For infants you will just look at the baby's face.
- For toddlers you can give him some freedom to move around the clinic so they can have more trust when examing them.
- In adolescents, they like to have their own privacy

the child's age – a key feature in the history and examination (Fig. 2.1) as it determines:
- the nature and presentation of illnesses, developmental or behaviour problems
- the way in which the history-taking and examination are conducted
- the way in which any subsequent management is organised

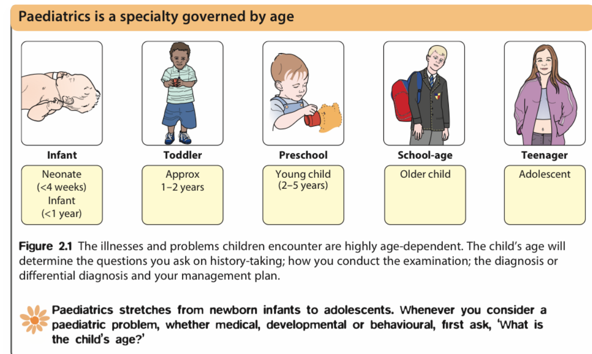


Figure 2.1 The illnesses and problems children encounter are highly age-dependent. The child's age will determine the questions you ask on history-taking; how you conduct the examination; the diagnosis or differential diagnosis and your management plan.

Paediatrics stretches from newborn infants to adolescents. Whenever you consider a paediatric problem, whether medical, developmental or behavioural, first ask, 'What is the child's age?'

Presenting Complaint

- Description of the presenting complaint, in chronological order.
- Including whether came in through Emergency Dept or admitted from OPD.

History of Presenting Complaint

Same as other types of hx but here we are adapting it for a pediatrics age of group

- SOCRATES:
- Time course: seasonal or diurnal fluctuation.
- Exacerbating factors: foods.
- Referral by clinic vs. came in through casualty.
- Relevant negatives.
- If using unusual words, ask for clarification.

History of Presenting Complaint

- SOCRATES:
- Site: where, local/ diffuse, "Show me where it is worst".
- Onset: rapid/ gradual, pattern, worse/ better, what did when symptom began.
- Character: vertigo/ lightheaded, pain: sharp/ dull/ stab/ burn/ cramp/ crushing.
- Radiation [usually just if pain].
- Alleviating factors, "What do you do after it comes on?"
- Time course: when last felt well, chronic: why came now.
- Exacerbating factors, "What are you doing when it comes on ?".
- Severity: scale of 1-10.
- Associated symptoms.
- Impact of symptoms on life: "Does it interrupt your life".

Past Medical, Surgical History

More benign than adults so usually you only have asthma
The co-morbitites are much less than the adults

- Past illnesses, operations.
- Childhood illness, obs/gyn.
  - Tests and treatment prescribed for these.
  - Problems with the anesthetic in surgery.
- Previous Blood Products transfusion?

Birth History

Obgyn have obstetric hx
But here we have birth hx which we call it gestational hx,
we focus on the fetus or the gestation itself

- Length of gestation. Preterm, full tem or post-term.
- Age and parity of mother at delivery.
- Any maternal insults [alcohol, smoking] or illnesses during gestation.
- Where born: city, hospital.
- Birth weight, mode of delivery, difficulties in delivery.
- Resuscitation, intensive care requirement at birth.
- Cyanosis, pallor, jaundice, convulsions, birthmarks, malformations, feeding or respiratory difficulties. General questions
- Apgar score at birth if known. If we can obtain it, it will support our history
- How baby was fed in first few days.
- Whether child went home with mother.

prenatal/birth history is mostly important for babies up to 2 months old.
for kids 12 y/o with convulsion and cerebral palsy; it's crucial to ask about birth history (perinatal hypoxia).

if another 12 y/o came for MVA birth history is not significant however go through it as a screening point (ask about: how is the birth? uneventful? full term? birth weight? discharge?)

When to focus on the birth history?

- Depends on the case for example if the patinet came with cerebral palsy I want to know if the pt had hypoxia to look for the reason of cerebral palsy..
- Example: 8 years old asthmatic, I wouldn't focus much here.. i will just ask normal delivery, child went home with mother and no ICU admission.
- Traditionally we put the birth weight.
- If the pt is in first few months of life I would ask all If these because it may be relevant. And here you can start your present history with the birth hx (ex: a full term 2 months old...)

Nutritional History

briefly in older kids

malnutrition is not only decreased feeding but also inappropriate nutrition (junk food)

- Breast-fed vs. bottle-fed
  - When breast started, stopped: Why? For how long was the baby breast fed and hwy was it stopped?
  - If formula: type, amount, pre-mixed vs concentrate [and dilution used]. Is it the correct dilution or not?
- Vitamin/Iron supplements. If he's on exclusively breast feeding, was he offered any vitamins or oral supplementations?
- Age when other diet was started.
- Appetite and growth.
- Current diet: Quality of Diet?

And again these questions depends on the age

Immunization History

Vaccination

Make sure it's according to the latest MOH schedule

- See the Most Recent National Vaccine Card
- Get dates of each.
- Any complication post previous vaccines?

And if there was a problem i have to ask how was it dealt with and explore it more (urticaria, anaphylaxis, fever?)

Developmental History

This is especially for < 5 years of age. And once they go older you can do DDST (denver developmental screening test)

If you'r not worried about any developmental delay just ask about the latest milestone:
- for a 6 months old ask about sitting w/o support.
- for a one year old ask about standing w/o support, and cruising around the furniture.

if the patient presented with a history of developmental delay you need to go into more details.

- Gross motor:
  - e.g. sitting and walking
- Fine motor:
  - Fine motor usually tests hand and vision
  - You test the vision together with the fine motor
  - e.g. Pincer grasp and scribble
- Vision, speech, hearing:
  - e.g. say "Mama""Baba" and two words sentence
- Social:
  - e.g. smiling, playing with others
- See Developmental Milestones Reference.

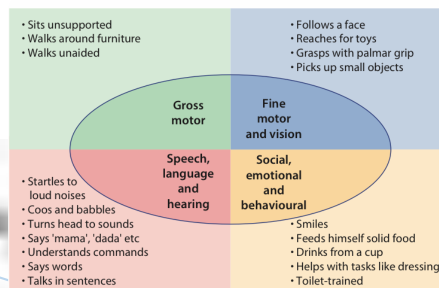


Figure 2.4 Some key developmental milestones in infants and young children. These are considered in detail in Chapter 3.

- The picture is from illustrated book

Education History

For older children

- Start of school attendance.
- School level and grades
- Relationship with Friends
- Special needs requirements. (educational)
- Impact of symptoms: absent school days.

How is the impact of the disease? Especially for chronic diseases like diabetes, sickle cell disease. It will affect them with many absent school days.

Family History

- Any similiar diseases in the family
- Any genetic predisposition
- Any unexplained deaths

- The current complaint in parents/ siblings: health, age of onset, ?cause of death.
- Parents/siblings: age, health, where living.
- Height and weight of parents. If you were concerning about growth retardation
- Hereditary & Consanguinity: do a family tree.

get familiar with family pedigree it may come in the exam (MCQ or OSCE) to determine the inheritence pattern

Social History

- Age, occupation of parents.
- Race and migration of parents [if relevant].
- Any others at daycare/ school with same complaint.
- Travel: where, how lived when there, immunization/ prophylactic status when went.
- Does the child live at home, and with whom [include siblings].
- Smokers in the home.
- Pets in the home.
- "Is there some things that worry you about the symptoms your child is having?" Open end question just to observe the family perception further

Drug History

- Prescriptions currently on: dose, when started, what for.
- Compliance.
- OTCs.
- Alternative / Herbal medications.

Please remember over the counter medications and in our society; herbal medications اليانسون والثوم

Allergy History

To medications or food

- Allergies, and reaction of each:
  - Eczema, asthma, hay fever, hives.
  - Drugs, foods, dyes.

Systems Review

- Screening: if any abnormality => Explore the details

one year old presented with severe diarrhea and vomiting for 2 days what are you going to ask about?

This is easy-difficult
Easy because it's systematic review
And difficult because you need to know how to do it right depending on the pts signs and symptoms
For example a pt with severe gastroenteritis came to you dehydrated and was admitted
What will you ask in systems review

- **CNS: LOC, lethargy, irritability, abnormal movements, seizure if the pt has severe electrolytes abnormalities**
- **Respiratory: SOB, tachypnea as compensation of metabolic acidosis, or maybe tachypnea bc the pt was triggered by a viral infection**

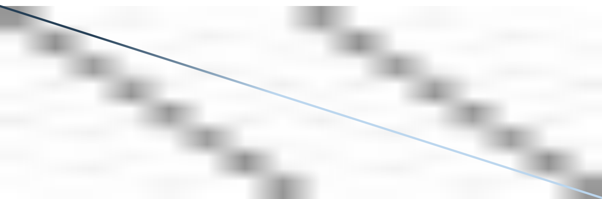
renal: quantity of the output…

History tips

- Ask if the temperature was actually measured, and if so, what it was.
- Some parents may exaggerate or mislead you so ask specific questions or underestimate
- Avoid leading questions! You can ask directly
- Show appreciation and empathy with parents anxiety and worry
- Be aware of the sensitivity of some issues in the family life
- Take note of the parents behavior Is it appropriate for the pts situation or not

Questions/Comments

- mtemsah@ksu.edu.sa



VISION رؤية 2030 المملكة العربية السعودية KINGDOM OF SAUDI ARABIA

جامعة الملك سعود King Saud University

CHILDREN SAFETY
ADOLESCENT MEDICINE

Hani Temsah

Associate Professor of Pediatrics

Pediatric Intensivist

Child Protection Team (KSUMC)

Fall, Crash and Slip

All part of being a kid

- Children are the future of the world and deserve their chance to succeed, cheered on by the caretakers and adults who surround them.

DIMENS CRIT CARE NURS. 2009

Agenda

- LEGISLATION
- SAFE KIDS:
  – from accidental & non-accidental injuries
- ADOLESCENT GROUP
- CHILDREN SAFEGUARDING

HUMAN RIGHTS

PREVENTABLE INJURIES ARE THE #1 KILLER OF KIDS IN THE U.S.

It's still a major concern

Every year, 9,000 families lose a child because of a preventable injury. When a child dies, the lives of families are changed forever.

IT'S A SERIOUS PROBLEM AROUND THE WORLD.

Globally, a child dies from a preventable injury every 30 seconds. Too many families don't have access to the information and resources they need to keep their kids safe from tragedies such as drownings, car crashes, fires and falls.

every 30 seconds

MILLIONS MORE CHILDREN ARE INJURED EVERY DAY.

In the United States nearly 9 million children are treated for injuries in emergency departments every year. These are often serious injuries that can affect them for a lifetime.

THIS IS A PROBLEM WE CAN FIX.

No parent should have to endure the loss of a child. Help us give all children the chance to grow up and become whatever they can imagine.

learn · educate · protect · act · donate

Preventable Injuries remain a major source of Childhood Morbidity:

- Unintentional Injuries in Families Visiting the Childhood Safety Campaign in Saudi Arabia

Preventable Injuries remain a major source of Childhood Mortality:

Unexpected Mortality and Parental Distress:

Drowning in the desert: family denial of brain death

- Unintentional injuries are still present in high percentage in our community.
- The worse than accidental injuries is the non-accidental = child abuse.

So, What is Abuse??

Milder cases of child abuse is unfortunately a misconception of parents that this is the way to discipline the child الضرب

Definitions from the **Council of Health Services, KSA**

- **The Child:**
- Any person who is less than **18 years** of age.

There's a difference between abuse and violence for example if you have a kid walking in the street and someone comes and hit them.. that's not an abuse its an assault. Abuse is not something that happens once and it's gone.

Violence against the Child:

- **All forms of physical, sexual, emotional maltreatment, as well as neglect or exploitation of the child by his/her parents or caregivers, which might affect the health, the development, or the dignity of the child.**

No case of child abuse is similar to the other, each case is different

Introduction

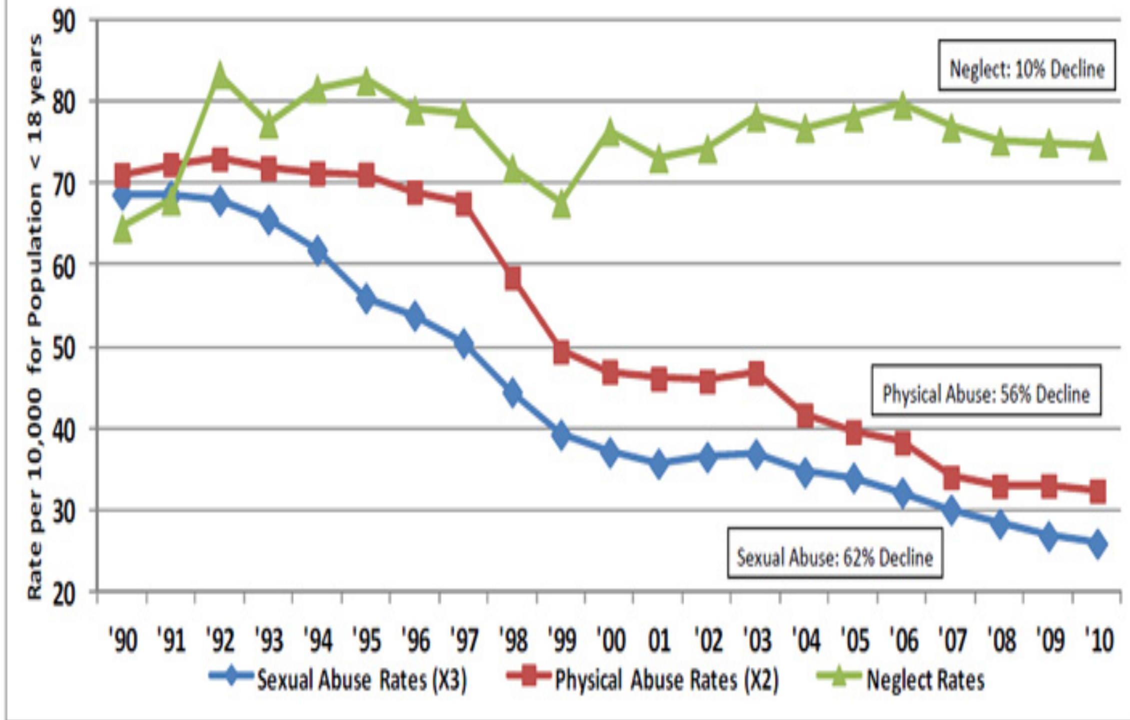
Before 1970 no one used to talk about it..
it was just part of discipline.

- In 1974, the Child Abuse Prevention and Treatment Act was signed into law in the US
- Defined as “the physical and mental injury, sexual abuse, negligent treatment or maltreatment of a child under the age of 18 by a person who is responsible for the child’s welfare under circumstances which indicate that the child’s heath and welfare is threatened or harmed.”

EPIDEMIOLOGY OF CHILD ABUSE: International

International wise

- More than 3 million reports are made to child protective authorities in the United States each year.
- Every year, nearly 1.4 million children (approximately 3% of the population < 18 y) are victimized in some manner.
- Child maltreatment is 12.3 per 1000 children.
- One in 50 infants are victims of nonfatal child abuse or neglect yearly.[1] Each year, 160,000 children experience serious or life-threatening injuries.
- Approximately 1500 children die each year from abusive injuries or neglect. Children aged 0-3 years are most likely to experience abuse; 79% of children killed are younger than 4.
- Many of these seriously injured and murdered children have presented to the ED for initial care



Note: Trend estimates represent total change from 1992 to 2010. Annual rates for physical abuse and sexual abuse have been multiplied by 2 and 3 respectively in Figure 1 so that trend comparisons can be highlighted.

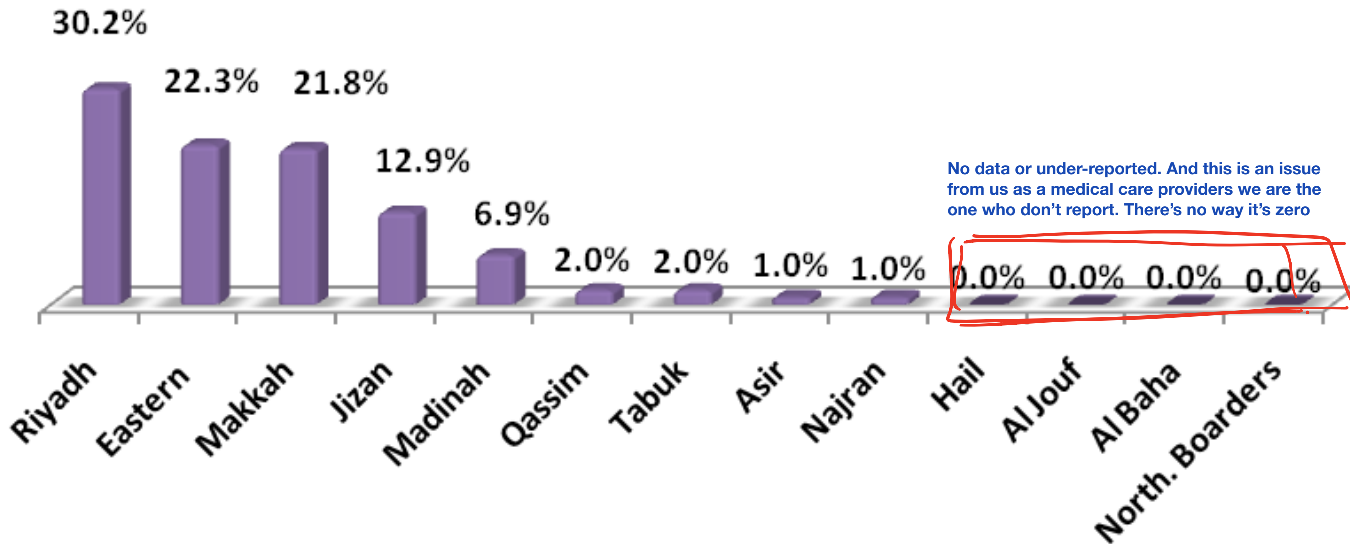
- With time: the two forms of abuses that we were really able to report and adress and manage are the physical abuse and sexual abuse which are with time trending down.
- However unfortunately child neglect is still not well controlled, it's still there and still high.

EPIDEMIOLOGY OF CHILD ABUSE: National

Local data

- In 2012 National Family Safety Program Report: 202 maltreated children
- 263 events reported by 21 (out of 41) of the child protection teams around the country
  - 53% required hospital admissions
- one-third (30.3%) of the maltreated children has had previous unreported maltreatment events; the majority of them were females

What does this mean? It means of these reported cases which are 200. We missed the 1st the diagnosis in one third of them. So please at least have a high index of suspicion. If you have something that doesn't add up or the hx doesn't explain much. Think about it! Could it be abuse? Don't ever say that this family is too good to do so



Child maltreatment cases in these regions could have been undiagnosed, not referred to the hospitals' child protection teams, or were not reported by the team to the registry..

Physical abuse

This is the most obvious form of abuses

- Impulsive reaction to environmental stressors where the perpetrator causes physical injury to a child, including anything from bruises, fractures, or brain damage

Emotional abuse

Difficult to detect

- More difficult to pinpoint
- involves a child's unmet emotional needs such as for affection, nurturing, and positive attention; instead, the caretaker rejects, terrorizes, verbally assaults, and attempts to destroy a child's self-esteem.

It's really bad.. it could be even worse than physical abuse

- It can be tied to poor knowledge of normal growth and development so that the parent expects a child to do or understand things beyond his/her years, even expecting the child to take on the parental role in the relationship.

Sexual abuse

- *The least reported.*
- any form of sexual contact or attempted contact between a child and a caregiver (or another adult) for the purposes of the adult's sexual gratification or financial benefit, including any injuries related to the sexual activity.
- Usually, the perpetrator is a male, but females also sexually abuse children, both with and without coercion by their partner.
- A woman who knows that sexual abuse is occurring to a child is considered as guilty as the perpetrator in a court of law.

Because she is considered also as legally responsible. This is important for us because we need someone to speak up for these children.

Neglect

- failure to provide for the minimum physical needs or the lack of appropriate supervision based on the child's age and developmental stage. not necessarily on purpose
  - This includes food, shelter, clothing, and heat, and for those children with health problems, it also includes any medications, treatments, and follow-up appointments that they require for ongoing care.

Part of neglect we see is the vaccination. It's a really common problem so do we consider it as a neglect? We do our rule as a physicians we remind the parents and follow up with them. If they persistently refuse then yes we put it under the umbrella of neglect.

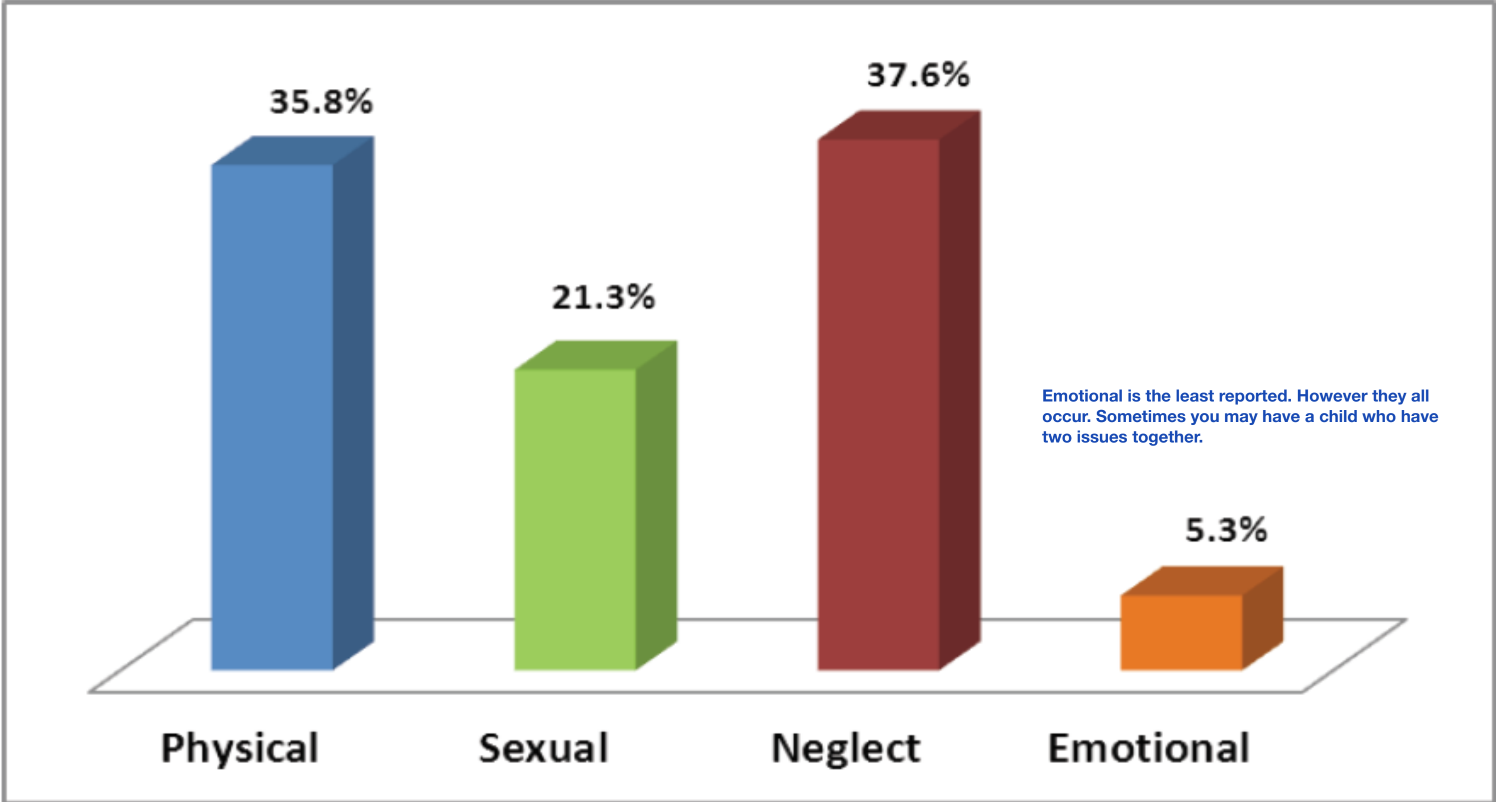
Munchausen syndrome by proxy

Very rare.

- when the parent or caretaker causes or fabricates an illness causing unnecessary medical evaluation and treatment that result in hospitalizations, morbidity, or death of the child.
- the most frequent parent involved is the mother

Maltreatment Registry
The Annual Report 2012

Fig. 1-1: Distribution of child maltreatment forms.



An important slide!
Where and when should I suspect that there's a non-accidental injury (red flags).

RECOGNISING ABUSE

The following should alert the clinician for a possibility of NAI:

- Discrepancy between history and injury seen "my baby fell of the crib" yet he's having a severe brain injury
- Changing story with time or different people
- Delay in reporting
- Unusual reaction to injury That's why during the hx we take notes about the parents reaction to the child injury
- Repeated injury
- History of NAI or suspicious injury in sibling Because sometimes it happens inside the family
- Signs of neglect or FTT Failure to thrive

The following non-specific signs **may** indicate something is wrong:

- Significant change in behaviour
- Extreme anger or sadness
- Aggressive and attention-seeking behaviour
- Suspicious bruises with unsatisfactory explanations
- Lack of self-esteem
- Self-injury
- Depression
- Age inappropriate sexual behaviour

Possible social and family indicators of abuse

Risk factors of non-accidental injuries:

Red flags

- Domestic Abuse

  For example a father who is abusing the child maybe also abusing the mother
- Alcohol Misuse
- Drug Misuse
- Mental Health Illness
- Frequent missed appointments (especially health)

Highly mobile families

Unstable families

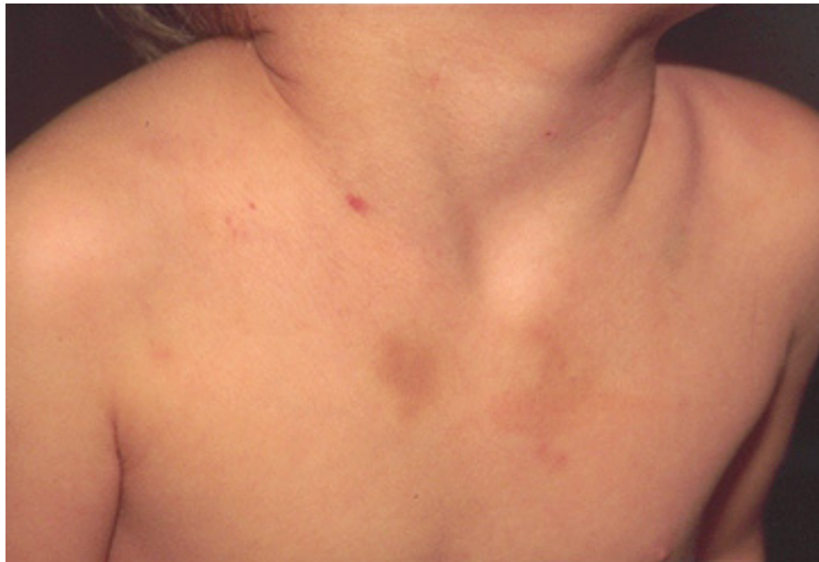
Living in poor conditions

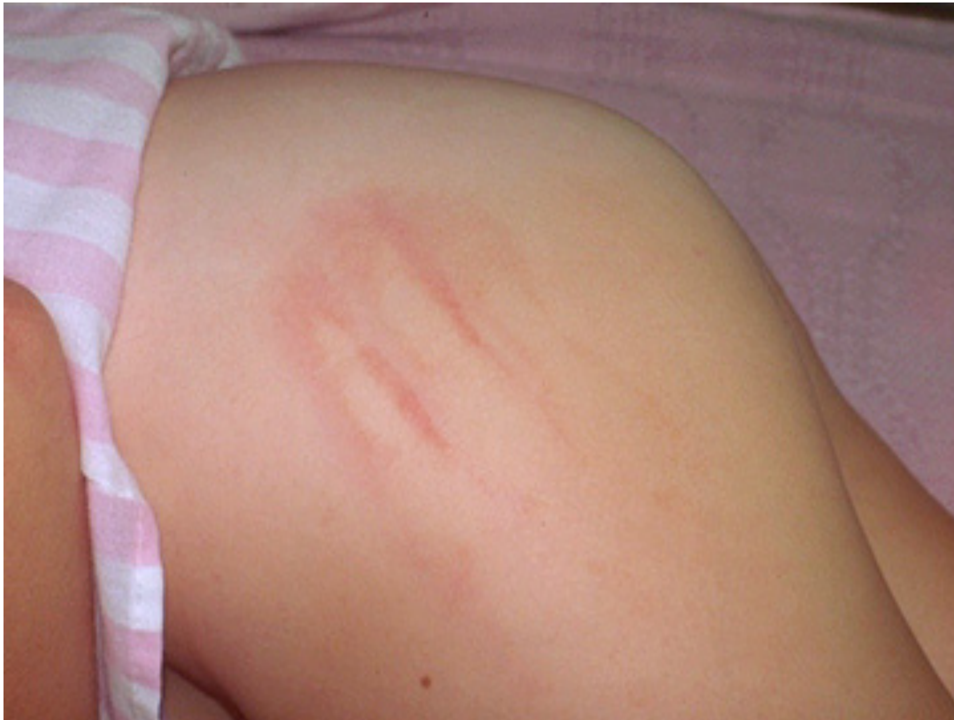
Criminality

Poor or negative family support

Un co-operative with services

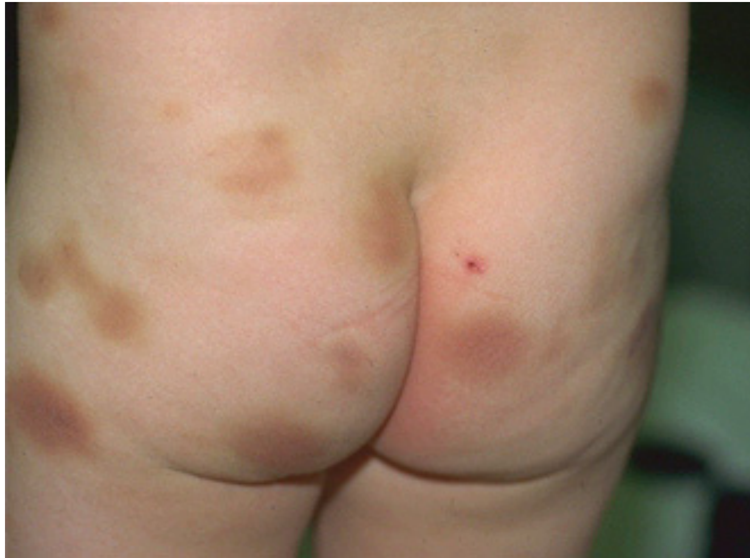
- Bruises of different ages that means they occured in different times.
- Bruises in odd places (in the chest).
- We check the coagulation profile for this pt and I don’t have bleeding tendency. But it could be expected if the pt has thrombocytopenia.



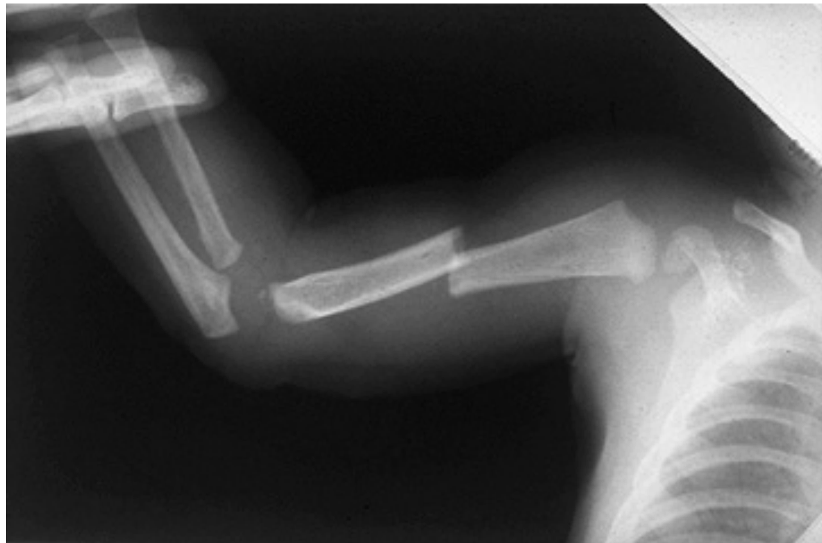


- A clear slap
- Sign of fingers

pictures need to be taken for medico-legal purposes
if the parents refuse -> document and refer to the child protection team

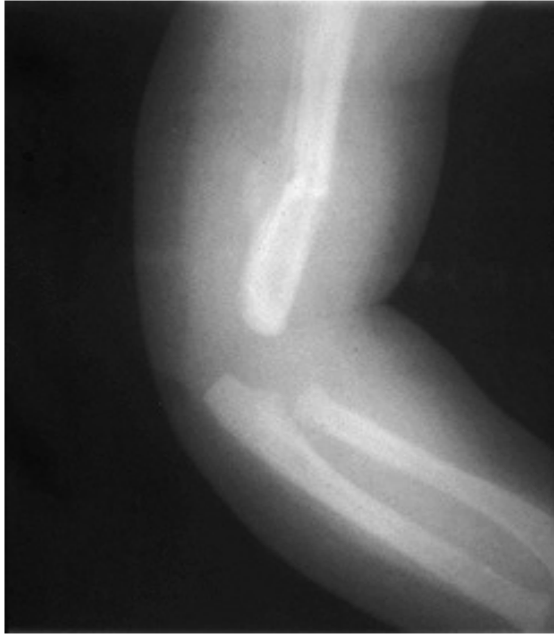


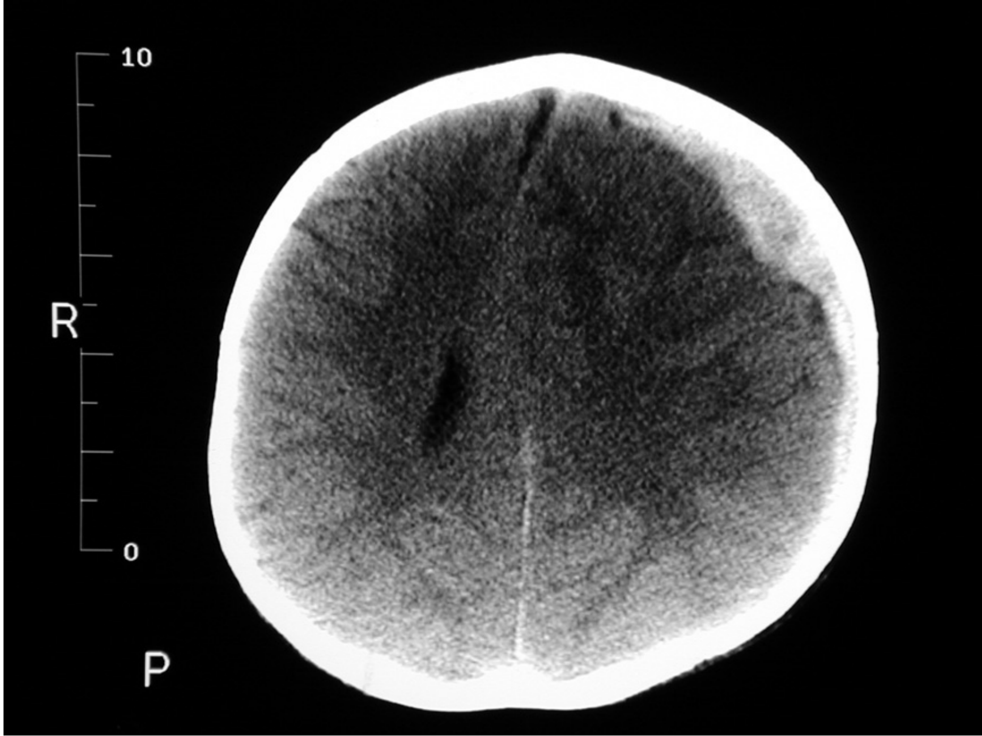
- Cigarette burn
- Different bruises from different ages, some are fading



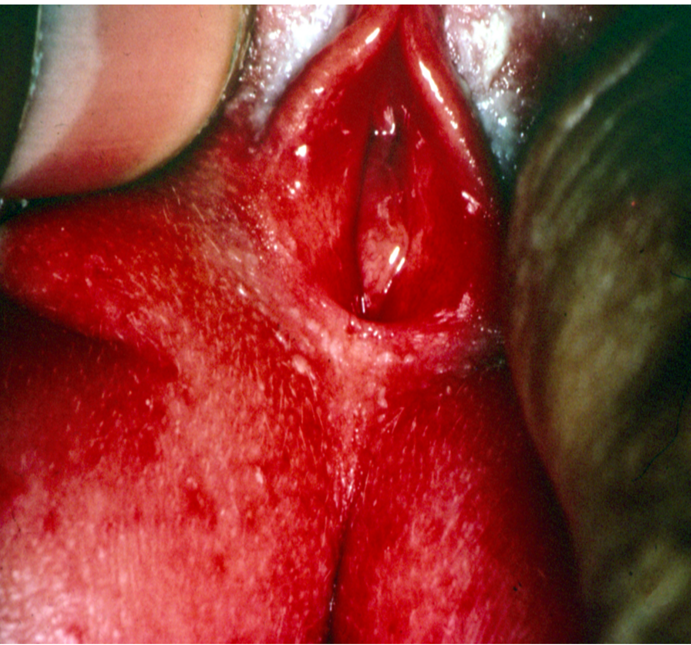
- Multiple fractures.
- They will just say he fell down but this is not the way you see these injuries.

Even if you just suspect it, alert the child protection team. You don’t need to prove it to alert it this is not your job. Proving it is for the child protection team and children services.



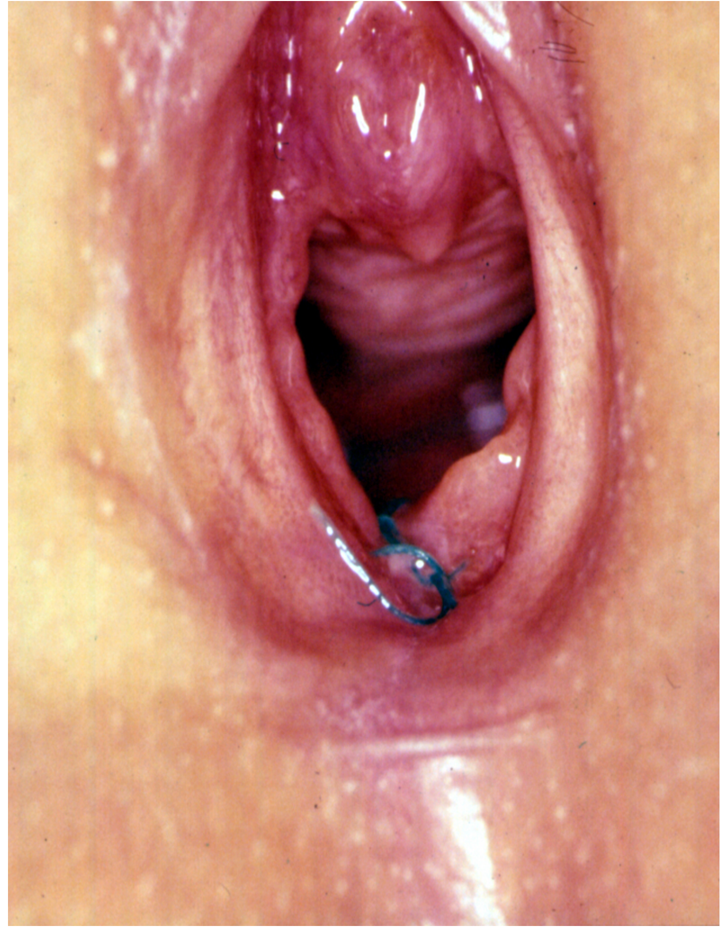


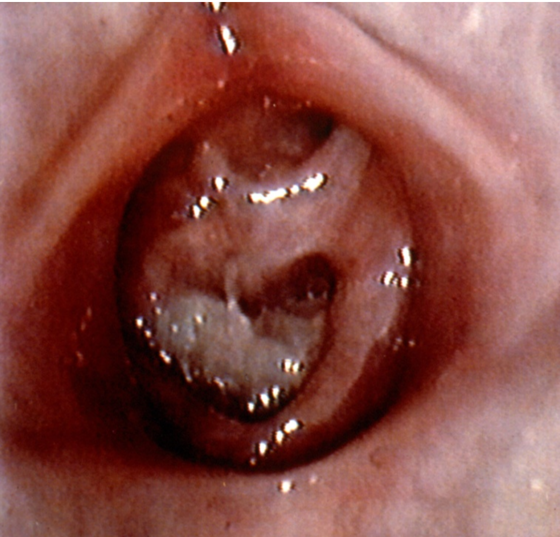
Epidural hematoma



Sexual Abuse

Ulcerations of sexual abuse





Examination

These physical exam findings must be documented, because when they go to the authority, the judge will look at medical records. Also because these findings will fade away with time.

- Bruises: in under 1 yr, finger marks, different ages, around wrists and ankles (swinging), inside and behind pinna (blow with hand), ring of bruises (bite mark)
- Two black eyes
- Strap or lash marks
- Torn frenulum: blow or forced feeding
- Small circular burns: Cigarette burns
- Burns or scalds of both feet or buttocks
- Fractured ribs: Shaking
  When the parents want to calm the baby down they shake them.. they end up with shaking baby syndrome giving fractured ribs, retinal hemorrhages and subdural hematomas.
- Epiphysis torn off: swinging
- Subdural haematoma: shaking
- Retinal haemorrahges: shaking
- Multiple injuries and injuries at different ages

Potential pitfalls

Not to confuse with abuse

- Mongolian spots bluish discoloration that will fade out with time
- Bleeding disorders: CBC and clotting profile
- Underlying bony disorder: OI, Copper deficiency – skeletal survey

That gives pathological fracture

COVID19 effects on Child Abuse?

trends of abuse are increasing

- AAP: financial, emotional and other stresses that parents face
- Many families spend long periods of time isolated at home
- children are at an increased risk of being abused

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Child-Abuse-and-Neglect/Pages/Prevention.aspx

Parenting in a Pandemic: Tips to Keep the Calm at Home

- https://www.healthychildren.org/English/health-issues/conditions/COVID-19/Pages/Parenting-in-a-Pandemic.aspx

WHAT TO DO IF YOU SUSPECT IT?

- Work in the best interest of the child: Full clinical assessment with Invx
- **Good documentation** and share your concerns despite uncertainties and insure child safety
- **Do not be judgemental** You just document and report
- Common assessment framework
- Robust referral system and clear pathway
- Features of safe culture:
  - Open, no secrets
  - Belief that 'it could happen here'
  - Clear procedures for reporting concerns
  - Support in raising concerns and commitment to take action
  - Code of conduct

Childhood Safety Tips:

Scan:

جُنّة

JUNNAH

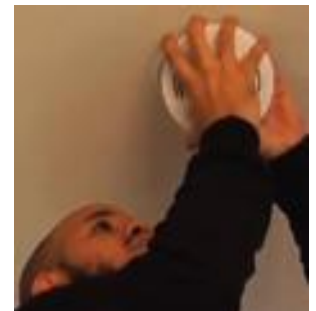
- For the accidental injuries they work with the Saudi pediatrics association group.
- They will probably do it afte Ramadan if you are interested.

SAFETY TIPS

- Pedestrian.
- Crossing the road

SAFETY TIPS

- Fire and heat: burns
- Furniture tip over
- Travelling



SAFETY TIPS

- Sports
- Playground

SAFETY TIPS

- Poisoning: drugs and others.
- Others: Suffocation, Inhalation, Drowning, Near drowning

ADOLECSENT MEDICINE

This population needs more effort

- Most vulnerable
- Copy each other
- Media/technology effect
- Psychosocial issues

- The 22 countries of the East Mediterranean Region (EMR) have large populations of adolescents aged 10-24 years.

What's the adolescents age?

There's no clear cut line for it but usually it's between the 12-18 and some people extend it upnto early 20's

- These adolescents are central to assuring the health, development, and peace of this region. We described their health needs.

Adolescents are usually influenced by their peers, parents and the society

- Tobacco smoking and high body mass were common health risks amongst adolescents.

Adolescent health in the Eastern Mediterranean Region: findings from the global burden of disease 2015 study

May 2018

HEEADSSS

It's not an easy tool and i'm not going to give a headache because of it.
It's a 360 assessment (full assessment for adolescents)

- ***A screening tool for conducting a comprehensive psychosocial*** history and health risk assessment with a young person

- ***HEEADSSS also provides an ideal format for a preventive health check***

- It provides information about the young person's functioning in key areas of their life:

H– Home
E – Education & Employment
E – Eating & Exercise
A – Activities & Peer Relationships
D – Drug Use/Cigarettes/Alcohol
S – Sexuality
S – Suicide, (Self harm) and Depression
S – Safety (and spirituality)

The role of HEEADSSS conversations

https://www.youtube.com/watch?v=FjVcTGnGQk8

This is a video about how to do the HEEADSSS conventions

Well adolescent care

360 degree

Holistic approach to provide care for adolescents with endocrine and/or other problems including liaison with other colleagues in different specialties such as: Dermatology, sexual health, gynaecology, mental health, Dietician, Psychology and Psychiatry as well as other heath agencies such as Mental health, Eating disorders, Birth control and Substance abuse.

Well adolescent care: Challenges

- Interview: move from norm to sensitive, ask for permission to ask sensitive questions.
- Confidentiality

Usually these are done without the parents present, otherwise they will not disclose. You can't ask sensitive questions in the present of parents

- Legal issues
- Chaperon: 3rd person approach (especially with female teenager))

if ur asking about smoking in a 14 y/o start with general non specific questions "what do you think about smoking? is smoking common among your community? do your friends smoke? have you tried smoking before? how was it?" and gradually escalate from there. Avoid judgement to keep the conversation going even if the act was against your beliefs

- Normal or abnormal? Puberty -Normal variants

H

The doctor skipped the HEEADSSS slides

Explore home situation, family life, relationships and stability:

Where do you live? Who lives at home with you?

Who is in your family (parents, siblings, extended family)?

What is your/your family's cultural background?

What language is spoken at home? Does the family have friends from outside its own cultural group/from the same cultural group?

Do you have your own room?

Have there been any recent changes in your family/home (moves; departures; etc.)?

How do you get along with mum and dad and other members of your family?

Are there any fights at home? If so, what do you and/or your family argue about the most?

Who are you closest to in your family?

Who could you go to if you needed help with a problem?

E

- ***Explore sense of belonging at school/work and relationships with teachers/peers/workmates; changes in performance:***

What do you like/not like about school (work)? What are you good at/ not good at?

How do you get along with teachers/other students/workmates?

How do you usually perform in different subjects?

What problems do you experience at school/work?

Some young people experience bullying at school, have you ever had to put up with this?

What are your goals for future education/employment?

Any recent changes in education/employment?

E

- ***Explore how they look after themselves; eating and sleeping patterns:***

What do you usually eat for breakfast/lunch/dinner?

Sometimes when people are stressed they can overeat, or under-eat – Do you ever find

yourself doing either of these?

Have there been any recent changes in your weight? In your dietary habits?

What do you like/not like about your body?

If screening more specifically for eating disorders you may ask about body image, the use of laxatives, diuretics, vomiting, excessive exercise, and rigid dietary restrictions to control weight.

What do you do for exercise?

How much exercise do you get in an average day/week?

A

- ***Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:***

What sort of things do you do in your free time out of school/work?

What do you like to do for fun?

Who are your main friends (at school/out of school)?

Do you have friends from outside your own cultural group/from the same cultural group?

How do you get on with others your own age?

How do you think your friends would describe you?

What are some of the things you like about yourself?

What sort of things do you like to do with your friends? How much television do you watch each night?

What's your favourite music?

Are you involved in sports/hobbies/clubs, etc.?

D

- ***Explore the context of substance use (if any) and risk taking behaviours:***

Many young people at your age are starting to experiment with cigarettes/ drugs/ alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances?

How about you, have you tried any? – ***if Yes, explore further***

How much do you use and how often?

How do you (and your friends) take/use them? – ***explore safe/unsafe use; binge drinking; etc.***

What effects does drug taking or smoking or alcohol, have on you?

Has your use increased recently?

What sort of things do you (& your friends) do when you take drugs/drink?

How do you pay for the drugs/alcohol?

Have you had any problems as a result of your alcohol/drug use (with police; school;

family; friends) ?

S

- ***Explore their knowledge, understanding, experience, sexual orientation and sexual practices – Look for risk taking behaviour/abuse:***

Many young people your age become interested in romance and sometimes sexual relationships. Have you been in any romantic relationships or been dating anyone?

Have you ever had a sexual relationship with a boy or a girl (or both)? – ***if Yes, explore further***

(If sexually active) What do you use to protect yourself (condoms, contraception)?

What do you know about contraception and protection against STIs?

How do you feel about relationships in general or about your own sexuality?

(For older adolescents) Do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning?

Have you ever felt pressured or uncomfortable about having sex?

S

Explore risk of mental health problems, strategies for coping and available support:

Sometimes when people feel really down they feel like hurting, or even killing themselves.

Have you ever felt that way?

Have you ever deliberately harmed or injured yourself (cutting, burning or putting yourself in unsafe situations – e.g. unsafe sex)?

What prevented you from going ahead with it?

How did you try to harm/kill yourself?

What happened to you after this?

What do you do if you are feeling sad, angry or hurt?

Do you feel sad or down more than usual? How long have you felt that way?

Have you lost interest in things you usually like?

How do you feel in yourself at the moment on a scale of 1 to 10?

Who can you talk to when you're feeling down?

How often do you feel this way?

How well do you usually sleep?

It's normal to feel anxious in certain situations – do you ever feel very anxious, nervous or stressed (e.g. in social situations)?

Have you ever felt really anxious all of a sudden – for particular reason?

Do you worry about your body or your weight? Do you do things to try and mange your weight (e.g. dieting)?

S

- Sun screen protection; immunisation; bullying; abuse; traumatic experiences; risky behaviours.
- Beliefs; religion; What helps them relax, escape? What gives them a sense of meaning?

Fall, Crash and Slip

All part of being a kid

CHILDREN SAFEGUARDING

- What is safeguarding?
- Wide definition, including the child protection

From accidental and non-accidental injuries

- Outcomes if every child matters?

- What is abuse?

PREREQUISITES

1. Understanding the principles and values essential for working with children and young people

2. Understanding health and safety requirements

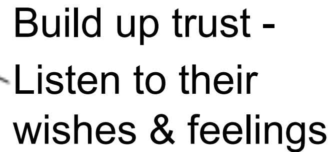
3. Knowing how to communicate effectively **With children, parents and your colleagues.**

4. Understanding the development of children and young people **Which will help you much**

5. **Context of Safeguarding Children**

6. CPD: developing yourself

What children want from health professionals?



Build up trust -
Listen to their
wishes & feelings

Comfortable with
sharing
information

Given time
to make
choices

To be kept
informed

Gain
consent

Services non-
stigmatised

Every Child Matters

Focuses on ensuring that all children and young people have the opportunity to achieve the five outcomes that are key to their well being in childhood and later life:

Make sure every child is:

- ① Be healthy
- ② Stay safe
- ③ Make a positive contribution
- ④ Enjoy and achieve
- ⑤ Achieve economic well being

WHO IS RESPONSIBLE?

Each one of you have some responsibility. كلكم راع وكلكم مسؤول عن رعيته

- Some people have specific responsibilities, **but everyone who works with children and young people has a part to play in helping to keep children and young people safe.**
- All practitioners have a role to play in supporting children to achieve the 5 every child matters outcomes – which includes ‘stay safe’.

CHILD PROTECTION

Is part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who suffered, are suffering or likely to suffer significant harm

WORKING TOGETHER FOR OUR KIDS

GET INVOLVED !

جُنّة ٣
JUNNAH

للاستزاده انظر الكتاب ص 493

QUESTIONS?

DISCUSSION

Want to get involved in Childhood Safety Campaign?

Email: mtemsah@ksu.edu.sa

WhatsApp 0554124457