



## Original research

# Skills for safe practice – A qualitative study to evaluate the use of simulation in safeguarding children teaching for pre-registration children's nurses

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## ABSTRACT

Safeguarding children teaching is a required component in all pre-registration nursing curricula. A structured approach to this teaching as part of preparation for registration as a children's nurse was developed jointly by the Course Leader and the Designated Nurse for Safeguarding Children. This approach aims to equip children's nurses with the necessary theoretical knowledge and practical skills needed for safe practice. A key element in this curriculum is simulation, where students must assess injuries on manikins, select and complete appropriate documentation, and perform a nursing handover. Simulation has recognised value in nurse education but its use in safeguarding children teaching for student children's nurses has not previously been widely reported.

This small-scale qualitative study explored the student experience and the impact of simulation teaching in the development of relevant knowledge and the core safeguarding skill set of observation, interpretation, documentation and communication.

The methodology for this small, qualitative study was triangulated, comprising observation of the simulation teaching and two sets of semi-structured interviews. The resultant data was investigated using thematic analysis.

The outcome of the study suggested that students were able to transfer learning from the simulation into clinical practice, and that simulation as an approach to safeguarding children teaching resonated with the students' preferred learning style and merits further consideration and evaluation.

## 1. Background

National guidance is clear that health professionals are in a strong position to identify safeguarding concerns and to respond appropriately (HM Government, 2018). Whilst not mentioned as a specific practitioner group within this guidance, children's nurses clearly play a crucial role in safeguarding vulnerable children and young people in various settings. Powell (2007), p.117 recognises that “Children, young people and families who are at a greater risk of child maltreatment are likely to have high levels of contact with a variety of health services.” Such vulnerable groups may include disabled children; children with complex or chronic health needs; children with learning disabilities; children with challenging behaviours; children and young people at risk of sexual exploitation (HM Government, 2018); and infants who were born prematurely (Boxwell, 2010). Such a high level of contact means that children's nurses are ideally placed to recognise those early indicators of stress in families, which could lead to attachment disorders, family dysfunction or child abuse and neglect.

Safeguarding interventions made by children's nurses may be at all

stages of the safeguarding children process – through Primary Prevention (preventing the occurrence of abuse and neglect); Secondary Prevention (early recognition of abuse and neglect and direct intervention to protect children and prevent further trauma); or Tertiary Prevention (ongoing support for children, families and carers to minimise the long-term sequelae of abuse and neglect). At all stages of the process, a high level of professional awareness, sensitive and empathetic practice needs to be combined with effective communication skills and multi-agency working.

Preparing students for this challenging and emotive arena of professional activity is an integral component of pre-registration education and the UK regulatory body (the Nursing and Midwifery Council) requires that programme providers equip students to “recognise and assess people at risk of harm and the situations that may put them at risk, ensuring prompt action is taken to safeguard those who are vulnerable.” (Nursing and Midwifery Council, 2018a, b, p.15). However, the nature of the course content is not specified in detail.

To further determine the essential elements of safeguarding education, it is necessary to turn to national training guidance first

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published by the Royal Colleges and professional bodies following the Laming recommendations into the death of Victoria Climbié (RCPCH, 2006). This was last revised in 2014 and a further revision is underway. It gives a detailed description of the required knowledge, skills, attitudes and values for all levels of healthcare staff according to the nature of their work and involvement with children and families (RCPCH, 2014). The guidance classes children's nurses as Level 3 practitioners. However, at the pre-registration level, students following all branch programmes are only required to be trained to Level 2.

Whatever the learning style of the individual student, it has been predicted that simulation as a teaching strategy makes a valuable contribution to nurse education (Alinier et al., 2006; Brooks et al., 2010; Cioffi, 2001; Moule et al., 2008). Simulation offers the student the opportunity to immerse themselves in a safe, clinical, learning environment and has the potential to stimulate all three domains of learning – cognitive, psychomotor and affective (Penn, 2008).

Simulation is an ethical means of practising skills without incurring risk to patients (Hayes et al., 2015). Mistakes made safely during the exercise offer opportunities for students to increase learning.

Simulation also offers a “range of learning opportunities not always available in practice” (Moule et al., 2008, p. 796), which can be repeated for a large number of students (Alinier et al., 2006; Penn, 2008). It can also facilitate the development of a range of nursing skills, (Prescott and Garside, 2009; Cantrell et al., 2008), and provide a controlled environment in which those skills can be assessed (McCallum, 2007).

Students have repeatedly evaluated simulation teaching very positively, even though it can sometimes be associated with high levels of anxiety (McCallum, 2007; Ker et al., 2003; Summers and Kingsland, 2009; and Baillie and Curzio, 2009). Students have also reported and demonstrated improved confidence in the nursing tasks rehearsed during simulation (McCallum, 2007; Prescott and Garside, 2009; Baillie and Curzio, 2009; Shepherd et al., 2010; and Cantrell et al., 2008).

All of these factors influenced the selection of simulation as one of the preferred teaching interventions in the safeguarding component of the pre-registration children's nursing curriculum at a large UK university: students are exposed to difficult situations, which they may not have encountered in the clinical arena, and may safely rehearse and develop the essential skill set required.

Prior to developing the simulation session, a literature review was undertaken to determine the required skill set for safeguarding. The skills identified are generic nursing skills, which have specific application in the field of safeguarding. They can be broadly assimilated into four categories:

1. Observation – good observational skills are required to pick up on the physical signs, behaviours and interactions which could suggest that risks are present in a situation or that a child may be the victim of abuse and/or neglect (Coyne et al., 2010; DfE, 2016).
2. Interpretation – “Professionals need to sift through the information, interpret its significance and make difficult judgements and decisions” (Williamson and Crozier, 2008, p.175). Nurses will often be faced with information generated through their own observations, conversations with parents and children, professional discussion and clinical records, and need some framework to make sense of this information and recognise inconsistencies (Coyne et al., 2010).
3. Documentation – in his report into the death of Victoria Climbié, Laming (2003) referred to the “consistent failure by doctors and nurses ... to record information comprehensively, to record and share concerns, and to record and complete the actions that the concerns prompted” (Laming, 2003, p.279). Since that report, the centrality of good documentation to nursing practice in general and safeguarding in particular has been reiterated in guidance documents (HM Gov, 2018; Nursing and Midwifery Council, 2018a,b).
4. Communication – in the context of safeguarding, nurses are required to establish and maintain good communication with children,

parents, families, nursing and medical colleagues and professionals from other agencies, sharing information as appropriate (Powell, 2016; Coyne et al., 2010)

Based on this required skill set, a simulation exercise was developed in which students working in small groups within the Clinical Simulation Unit are assigned to a particular “patient”. Each patient has some physical signs of abuse or neglect (e.g. an adult bite mark) and a small amount of background information is provided. After a brief introduction, students are tasked to assess their patient; select appropriate documentation from a small selection available; record their observations and provide an analysis of any safeguarding concerns identified. Each group then presents a nursing handover to their colleagues, including suggested management plans for each patient. The session concludes with a brief exercise to bring the students out of role and an opportunity to reflect on learning outcomes. At all stages of the day, the two session facilitators are on hand to support and direct the students, particularly any who are adversely affected by the experience of dealing with situations involving child abuse and neglect.

The simulation session builds on an initial theoretical introduction to safeguarding children and is jointly delivered by the course leader and the local Designated Nurse for Safeguarding Children – an approach which strives to model the desired theory to practice link for students.

## 2. Objectives

Simulation as a method of delivery for safeguarding children teaching has not previously been widely reported in pre-registration preparation of children's nurses. This small study was developed to provide a formal evaluation to assess the value of this approach, with the following key aims:

1. To critically evaluate the content and mode of delivery of a specific teaching intervention as part of a programme of pre-registration education in relation to safeguarding children.
2. To gain insight into the students' perception of the use of simulation as a method for developing knowledge and skills in child protection scenarios.
3. To assess what impact the teaching intervention had on the development of specific safeguarding skills and knowledge.
4. To consider whether simulation could be a valid tool for developing safeguarding skills and knowledge in pre-registration nurse education.

## 3. Methodology

The study was a small-scale qualitative study, which looked at the impact of the safeguarding children simulation intervention with a single cohort of pre-registration child branch nursing students at a large university. Qualitative studies reviewing simulation suggest that the approach is highly effective in developing relevant skills (Moule et al., 2008; Hayes et al., 2015). Other, quantitative studies are based on assessed student performance before and/or after the teaching intervention (Alinier et al., 2006; Roberts, 2000; Shepherd et al., 2010). Whilst such studies have produced demonstrable improvements in practice, their reliance on student assessment rendered them unsuitable for use in this particular instance since the session does not form part of the university's summative assessment schedule. Moreover, to undertake this research project using only a quantitative approach would be to overlook the essential human experience of relating to situations where children may have been subject to abuse or neglect. A qualitative research methodology potentially allows the researcher to better explore these particular relational factors in the teaching situation and their impact upon learning, decision-making and performance.

### 3.1. Sample

Sampling was purposive and consisted of a single cohort of second year student children's nurses, of which six elected to take part. However, all students in the cohort consented to an independent observer being present during the simulation exercise.

### 3.2. Ethical approval

Ethical approval was secured from the ethics committees of the participating and supervising universities.

### 3.3. Data collection

Data collection employed two different research tools within the single methodological context. The simulation teaching session itself was observed by an independent observer using a structured observation schedule based on the literature review. This considered evidence of psychological and engineering and any barriers to learning. This approach was designed to achieve the degree of critical evaluation required for the study and also addressed the issue of possible insider bias (since the researcher was also facilitating the simulation exercise). The independent observer was an experienced safeguarding children nurse with an academic background who had no previous knowledge of the teaching intervention or of the students involved. She did not participate in the teaching or interact with the students. The recordings made by the independent observer added a degree of contextual information, which would not otherwise have been available to the researcher (Patton, 2002). They also offered insight into the ways in which students interacted together (Casey, 2006) which would have been absent from interviews alone.

Two sets of semi-structured interviews were then conducted with participating students – the first shortly after the teaching intervention, and the second three months later, following a practice placement. The first set of interviews was aimed at exploring how the students had actually experienced the simulation exercise, whether or not the simulation had evidenced good engineering and psychological fidelity, and whether the students could identify the use of the four key safeguarding skills.

The focus of the second interviews was the relationship between the simulation session and situations encountered during clinical placements – had the students been able to translate any learning into practice?

### 3.4. Ethical considerations

Safeguarding children work always raises complex issues in relation to confidentiality. If, during the context of the study, any student disclosed information which would give rise to concerns about the safety and welfare of a child, or about professional practice, that information would have to be shared with the appropriate statutory and/or educational bodies. This caveat to confidentiality was clearly explained to the students before they consented to take part in the study.

Additionally, if at any point in the study, any student had become overly distressed by the subject matter; they would have the opportunity to withdraw from the study. All participating students were directed within the consent form to available sources of help and support.

Fortunately, it was not necessary to action either of these provisions during the course of the study.

### 3.5. Data analysis

Data from the independent observer was recorded on the observation schedule.

Data from both sets of semi-structured interviews was recorded using a high specification digital recording device (consent having been

obtained from participating students). The recordings were then transcribed in preparation for analysis.

Data was then analysed using thematic analysis and the relationships between and within categories explored. Data from the semi-structured interviews was triangulated with data from the independent observer. Thus, theories generated from the interview data could be tested against the observational data to give “complexity, richness and depth” (Denzin and Lincoln, 1994, p.7).

## 4. Results and discussion

The findings from the study will be discussed in terms of the broad aims of the study:

### 4.1. Evaluation of the simulation exercise

In evaluating simulation exercises, it is necessary to consider the extent to which the exercise achieves engineering and psychological fidelity. Engineering fidelity is defined as “the degree in which the simulation depicts the real environment and equipment within which the student is required to perform.” (McCallum, 2007, p.826). The depiction of injuries was one of the chief challenges presented in this study since there are no commercially available simulated injuries of the type required. This necessitated the author learning moulage techniques and working from clinical photographs to reproduce the necessary simulation scenarios. Interestingly, the students reported that the injuries mimicked real-life to an acceptable degree:

*“I’ve seen the same incident, like a bite mark, when I’ve been on one of my placements, so it looked basically the same.”*

This reflection was supported by the independent observer who had noted that the students referred to the injuries directly as “bruises”, “scratches”, a “bite mark” and “nail marks”.

It is of note that several of the students commented on the importance of the exercise being situated in the clinical simulation unit within the department as supporting the creation of “reality”.

Psychological fidelity is described as “how realistic the student finds the simulation and subsequently how they respond.” (McCallum, 2007, p.826). In assessing the degree of psychological fidelity achieved, the comments of the independent observer were particularly insightful. She noted that initially, the responses to the manikins were muted with few verbal or non-verbal cues to evidence any meaningful interaction. At this point, the students were clearly focused on reading the background information, assimilating the tasks and selecting appropriate documentation. However, as the exercise progressed and the students started to handle and examine their ‘patients’, the response in all but one of the scenarios suggested that the students were relating to the exercise on an emotional as well as a practical level. This observation was supported by interview data, with one student commenting that they were “very attached to the baby as a real-life person.”

The exception scenario related to a case involving a larger child manikin, which was heavy and difficult to handle and which was presenting with signs of neglect. The interface between the students and this manikin was explored during the first interview and group members reflected that they were more focused on the set tasks than on the nurse/patient interaction.

From data collected at interview, it appears that psychological fidelity can be further evidenced in the response of the students towards the manikins not just as real children, but also as potential victims of abuse or neglect. Several interviewees commented on their feelings of sadness, anger, and a desire to protect:

*“I felt quite sorry for it. And I felt the normal feelings –like when I know the child’s been abused. I felt really angry about the situation.”*

*“...protective over them – very protective.”*

The independent observer recorded similar reactions during the exercise:

*“It makes me really angry this does.”*

*“Why would anyone hurt a baby like this?”*

Such feelings are not uncommon reactions to child welfare situations, and one outcome of this session for some students was that they were able to identify and express their emotions as well as recognising that as professionals, such emotions must be appropriately managed:

*“So I think it was good in that aspect because I could learn to deal with those feelings...”*

#### 4.2. Students' perception of the use of simulation as method for developing knowledge and skills

The students reported that their skills of documentation and communication had been particularly developed through the simulation exercise. Through practising documentation skills, particularly the use of body maps, students felt they had recognised the importance of fine detail when recording injuries and situations: the need to accurately note factors such as location, size, shape and colour of lesions was something they had not previously appreciated. The comment from one student suggests that the critical importance of documentation in clinical safeguarding practice had really struck a chord:

*...if you don't get it right, it's not – someone else reading it won't make any sense and if you miss something, that could be the one thing that helps that child be protected.”*

Whilst the students had certainly observed patient handovers during clinical placements in their first year of training, very few of them had actually had the opportunity to deliver a handover report themselves. Such lack of experience did mean that this element of the simulation exercise was “challenging”! However, in the interviews, the practical experience of summarising patient information to fellow students was seen as a useful rehearsal for clinical work and, again, the critical importance of this skill was recognised:

*“...we've got to make sure we tell these people exactly what we've found because if we don't do it right even if we've documented it, if we don't get this handover right, we're going to leave and this process (i.e. the child protection process) isn't going to happen.”*

Other learning outcomes identified by the students included the importance of teamwork, owning your concerns and not making assumptions – all critical concepts in the context of safeguarding children work. One student reflected that they felt more confident and prepared for their next clinical placement – their first in a paediatric setting.

#### 4.3. Impact of simulation teaching on clinical practice skills

By the time of the second set of interviews, the study group had experienced a variety of clinical placement settings. Whilst all students did come into contact with children who had been involved in the child protection process, their exposure to the process and the nature of their involvement with such situations varied greatly. Whatever their level of involvement, all the students were able to articulate ways in which the skill set rehearsed during the teaching session had been put into practice in the clinical setting. They described having a “heightened sense of awareness” whilst involved in delivering clinical care, and of understanding the need for thoughtful observation and accurate documentation. They could also relate instances whereby they had to synthesise information and form hypotheses regarding the nature and degree of risk:

*“In both of them (clinical scenarios) it seemed an obvious thing for me to kind of look at that and think ‘well, is that child in any danger?’ and*

*trying to weigh things up.”*

The entire study group had been involved in writing up clinical notes and all described how they had strived to write “detailed” and “descriptive” accounts. They felt confident that they would know how to document any identified safeguarding concerns.

Whilst few of the students had had the opportunity to rehearse their communication skills via a nursing handover, they described other situations where these skills were required, for example during a CAF (Common Assessment Framework) meeting.

The experience of one particular student stands out as exemplifying the impact of the simulation session on practice:

On placement with a community paediatric team, one student had undertaken a visit with a Nursery Nurse to a family with a child who had feeding problems. Throughout the visit, the student had registered a number of concerns about the physical environment of the home, the lack of supervision of the children and the manner in which the mother spoke to and about the children.

The student observed the mother feeding her child and noted that “she would jab (the spoon) into his mouth so she'd catch his tongue on the bottom. It would be “in, in” and so he had a sore under the tongue ... when I started feeding him I could see that he had a big cut under his tongue.”

Based on her observations and knowledge, the student concluded that the children were at ongoing risk of harm. Whilst her Nursery Nurse colleague had concluded that, the situation was “fine” and mum was just “stressed”, the student persisted in her concern and raised the issue with her practice mentor.

The student was clear that she needed to record her concerns clearly: “I had to document what I'd heard and what I'd seen in the house ... But if it's not exactly right then it wouldn't be good enough – they (Social Workers) wouldn't have a leg to stand on.”

The outcome of this incident was a child protection referral to Children's Social Care. The student had then undertaken a difficult visit with her mentor to the family to explain the necessity for the referral, and had subsequently attended a multi-agency strategy meeting where other professionals had shared their concerns.

Following a detailed assessment, the children were accommodated by the Local Authority.

The student reflected: “If I hadn't had the session I know I wouldn't have picked up on what was actually going on in that house and I know it wouldn't have gone any further so the children would still be there ...”

#### 4.4. Could simulation be a valid tool for developing safeguarding skills and knowledge in pre-registration nurse education?

The data analysis suggested that students were able to demonstrate use of the four core skills in clinical practice and had a good level of knowledge of relevant issues. During the interviews, the students' responses were explored to better understand any direct relationship between their learning and the actual mode of teaching delivery. A clear picture of learning styles emerged, with students describing how they learn better through practical sessions:

*“I think generally if you've done it, you're more likely to remember it, rather than if you've read it or if somebody's told you.”*

However, one of the shortcomings of this study was the lack of any pre-existing data in relation to students' knowledge and skills with which to compare performance. Thus, whilst the data suggests a strong causal association between the teaching intervention, knowledge acquisition and clinical skills, this association cannot be conclusively demonstrated.

## 5. Conclusions

This is a small-scale study, which has relied on the views of a limited number of participants. However, the results are encouraging and suggest that the selection of simulation as a teaching approach to developing knowledge and skills in respect of safeguarding children does merit further exploration:

- The simulation exercise was evaluated positively by students. They reported they had enjoyed the experiences of taking part in the session and felt that the practical approach to the subject had resonated with their preferred style of learning.
- Despite some of the practical challenges, the simulation session appeared to achieve a good degree of engineering and psychological fidelity.
- Following clinical placements, all participating students were able to identify that they had utilised the core skill set rehearsed during the simulation session, both in generic nursing practice and in relation to safeguarding children situations. Students also identified other skills (e.g. teamwork) which are crucial elements of safeguarding practice. However, it must be acknowledged that this study has relied on the reported experience of participants. In order to more fully demonstrate the impact of the session on skill development, it would be necessary to utilise some form of performance measurement before and after the teaching intervention.
- In the absence of any comparative data collected before the session, it is not possible to confidently assert that the students' knowledge base developed directly as a consequence of the simulation session. However, evidence from students' accounts suggests that they did demonstrate a good awareness of key concepts in practice.
- Several students reported an increase in their levels of confidence in matters relating to safeguarding practice, to the extent that they had felt able to challenge and question more senior colleagues and staff.

Based on the findings from this study, the simulation session will continue to form a key part in the curriculum for pre-registration safeguarding education in the study setting. The approach has also been extended to the midwifery setting, using adult and infant manikins and patient-held records. Informal feedback from participants has been extremely positive and this is forming the basis for further study.

At the present time there is a pervading political climate of renewed drive towards timely and effective interventions to improve outcomes for children and young people, and a sustained professional focus on competent and compassionate care – all set within the challenging context of the current austerity measures. The educational preparation of the next generation of children's nurses for safeguarding work has rarely been so critical. The small contribution made by this study may challenge us as educators to consider how we will develop safe and competent practitioners who can skillfully and knowledgeably safeguard their vulnerable charges.

## Conflict of Interest

None known.

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## Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.nepr.2018.11.009>.

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