Optimising Quality Care for Hospitalised Children

The Establishment & Development of a Paediatric Early Warning Assessment Tool

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England
Aim of Presentation

- Context of the Early Warning Assessment Tool / Medical Emergency Team / Outreach Team Development

- Development of the Bristol Paediatric Early Warning Tool
  - Research Study
  - Implementation of Tool
  - Evaluation

- Critical Care Outreach Team

- Current / Future Developments
The Medical Emergency Team: a new strategy to identify and intervene in high-risk patients

F HOURIHAN, G BISHOP, K M HILLMAN, K DAPFURN, A LEE

Abstract

Objective: To describe the utilisation of an emergency team that employs standardised calling criteria to facilitate the early identification and resuscitation of patients who are at risk of cardiopulmonary arrest.

Design: A prospective study of all Medical Emergency Team calls over a six-month period in 1994.

Setting: A 460-bed university teaching hospital in Sydney, Australia.

Subjects: Inpatients and outpatients who required Medical Emergency Team intervention.

Key words:
- Cardiopulmonary resuscitation (CPR)
- Critical care
- Heart arrest
- Medical emergency treatment
- Resuscitation
The Medical Emergency Team
A. LEY, G. BISHOP, B. M. MILLMAN, E. DUFFEY
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SUMMARY
The concept of a Medical Emergency Team has been developed as a system to rapidly identify and manage seriously ill patients at risk of cardiorespiratory arrest and other life-threatening conditions. The design of this study was to determine the incidence and outcomes of Medical Emergency Team interventions over an 18-month period at a teaching hospital in South West England. Data was collected prospectively using a standardised form. Cardiorespiratory arrests occurred in 370/132 (27%) calls, and on physiological and anatomical examination were in 299/132 (23%) calls. Survival rate to hospital discharge following cardiorespiratory arrest was 21% (39/178), compared with other medical emergencies (7%). Keywords: cardiac arrest, resuscitation, medical emergency team, cardiac arrest

Identifying the general ward patient at high risk of cardiac arrest

MORRIS, G. R. WARD, R. LAMBERT, AND E. P. BRENNER

Confidential inquiry into quality of care before admission to intensive care

Peter McQuillan, Sally Pilling, Alison Allan, Bruce Taylor, Alastair Short, Giles Morgan, Mick Nielsen, David Barrett, Gary Smith

The patient-at-risk team: identifying and managing seriously ill ward patients

D. R. Goldhill, L. Worthington, A. Mulcahy, M. Tatling and A. Sumner

Effects of a medical emergency team on reduction of incidence of and mortality from unexpected cardiac arrests in hospital: preliminary study

Michael D. Buist, Gaye E. Moore, Stephen A. Bernard, Bruce P. Wixman, Jeremy N. Anderson, Tuan V. Nguyen
Identifying the need for MET / Calling Criteria & Assessment Systems / Outreach Services

- Recognition of inadequate assessment & treatment of ward based patients → cardiac arrest
- Suggested that early recognition & treatment → improve patient outcome & prevent cardiac arrest

Achieved by:
- Provision of support by calling criteria or assessment systems / direct care delivery, advice and/or guidance

Purpose:
- Improve patient outcome
- Prevent cardiac arrest & averting admissions to critical care units
- Enabling discharges from critical care units
- Sharing and developing of critical care skills throughout the hospital
And in paediatrics ....?

- In early 2000, nothing published related to children and calling criteria, assessment tools or outreach services
- Small pockets of work / interest in Melbourne & UK
- Further investigation required

Acutely ill children within ward areas – care provision and possible development strategies

Report from a 2003 Nursing Travel Scholarship awarded by the Florence Nightingale Foundation through the generosity of The Nestlé Charitable Trust

Caroline Haines

Abstract

This report presents the key findings of a travel scholarship on critical paediatric centres in the United Kingdom (UK), Australia and the United States of America, where priority provision for the care of acutely ill children within ward areas is recognised. In total, 10 centres were visited over 4 rounds, and comprehensive programs of information and resources were assessed in all locations.

Key areas of interest identified were the concepts of paediatric critical care outreach services and the use of paediatric early warning assessment tools. Information was collected and applied to the existing service provision within a tertiary Children's Hospital in the UK.

It is hoped that the information gained during this research will contribute to the current available literature. It has helped to clarify the position of a number of key centres with regards to the care provision for acutely ill children in ward areas, and outlined the potential value of a support system and the use of early detection tools for staff caring for these children.

Key words: Multidisciplinary • nursing • Paediatric critical care outreach • Paediatric early warning assessment • Paediatric intensive care
Rationalising the need for an improvement in safety, & quality care at the Children’s Hospital in Bristol

- Increasing technology available within health care
- Increased acuity of children in ward areas
- Reduced number of skilled (deskilled) nursing staff in ward areas
- Reduced experience of junior medical staff in ward areas
- More specifically...
  - Gap in service between PICU & ward areas
  - Complaints
  - Increase number of ward-based critical incident events
  - Anecdotal information
Map of Great Britain

<table>
<thead>
<tr>
<th></th>
<th>Total Resident Population</th>
<th>Resident Population of Children under 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>59,756,000</td>
<td>19,540,212</td>
</tr>
<tr>
<td>England</td>
<td>49,997,000</td>
<td>16,289,022</td>
</tr>
<tr>
<td>Wales</td>
<td>2,946,000</td>
<td>969,856</td>
</tr>
<tr>
<td>South West</td>
<td>4,975,000</td>
<td>1,587,025</td>
</tr>
</tbody>
</table>

Bristol Royal Hospital for Children
Structure of Bristol Royal Hospital for Children (BRHC)

- **South West Regional Services**
  - Paediatric Intensive Care
  - Cardiac (including South Wales)
  - Renal
  - Bone Marrow Transplant

- **Mixed speciality wards**
  - Paediatric surgery
  - Neurology
  - Respiratory / ENT
  - Endocrinology

- **High dependency care provision for the local population**
High Dependency Facilities at BRHC

- No dedicated high dependency area within the hospital
- Significant amount of high dependency undertaken in PICU
  - 21% of admissions to PICU – Level 1 (PIC Report 2004)
- High dependency patients currently cared for in virtually every area of the hospital
  - Totalled 9% of all hospital admissions (CICS Data 2003)
- Exact enormity of the need unclear
## Annual Unplanned Admissions from BRHC Wards to PICU 2002 & 2003

<table>
<thead>
<tr>
<th>Ward Area</th>
<th>Total in 2002</th>
<th>Total 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMT – Bone Marrow Transplant</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Surgical Ward</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Cardiac Ward</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>Medical Ward</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Oncology ward</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Adolescent Ward</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Short Stay Surgical Ward</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Renal Ward</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Observation Ward</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>78</strong></td>
<td><strong>90</strong></td>
</tr>
</tbody>
</table>
Clinical Scenario

- 6/12 old infant – bronchiolitis – Day 2 of admission
- Increasing respiratory distress documented on observation chart for 4-6 hrs
  - ? resps & resession, ?HR, in headbox 50% O₂, pale in colour
- Being orally fed ... child out of oxygen SpO₂ not picking up
- Child became floppy, mottled, prolonged apnoea
- Cardiac arrest team called....
- Intubated & transferred to PIC
Promoting care for acutely ill children—Development and evaluation of a Paediatric Early Warning Tool

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KEYWORDS

Paediatric early warning tool
Paediatric intensive care
Paediatric critical care
Paediatric early warning
Paediatric intensive care

Summary

The primary purpose of this paper was to develop and evaluate a physiologically based system for the identification of acutely ill children in hospital environments. The recognition of children in hospitals is increasing and ensuring the appropriate medical intervention by a team of healthcare professionals in the care of these children is paramount to ensure their optimal outcome. A paediatric early warning (PEW) tool was designed and demographic and physiological data collected on all children (n = 369) who triggered the tool over a 6-month period, between September 2003 and February 2004. Analysis of the data was undertaken on each criterion within the tool and by reviewing it against patient outcome, the decision for its retention or removal was made. The modified tool showed a 99% sensitivity and a 66% specificity.

The resultant Paediatric Early Warning tool has been validated for use in a tertiary children’s hospital in the United Kingdom (UK). The use of such a tool by all staff caring for acutely ill children in hospital environments can help to ensure their early recognition and timely intervention. The tool, together with an action plan manual, however, is appropriate for use in individual wards or hospital areas.
Research Study

**Sample**
- Convenient sample
- 6-months – September 2003 - February 2004
- Those children who met a predetermined criteria, n=360

**Data Collection**
- x3 days/wk – research nurse
- All in-patient areas (excluding A&E)
- Demographic and physiological data was collected
# Data Collection Tool – Paediatric Early Warning (PEW) Tool

## Useful discriminators
- [x] Criteria that needed modification
- [ ] Poor discriminator
- [ ] Project group decision

## Bristol Paediatric Early Warning Tool

### A. Acute Airway Obstruction
1. Child has required nebulised adrenaline
2. Clinically tiring or implying complete airway obstruction
3. Child has suspected epiglottitis

### B. Breathing
1. Status asthmaticus not responding to bronchostatics or bronchodilators
2. SO₂ < 93% in any amount of oxygen
3. SaO₂ < 75% in any amount of oxygen (cyanotic heart disease)
4. Pulseless tachypnoea (RR > 70 under 6 mo, > 60 6–12 mo, > 40 1–5 yrs, > 30 over 6 yrs)
5. Apnoea / Bradycardia
6. Exhaustion and depressed mental status with respiratory distress
7. Respiratory acidosis with pH < 7.25 or pCO₂ > 50 mmHg

### C. Circulation
1. Persistent tachycardia / shock following 2 x 20 ml/kg fluid boluses (normal HR < 1yr 100–150, 1–5yr 100–150, 5–12yr 80–120, >12yr 90–100)
2. Bradycardia – below normal range
3. Shock (decreased BP or prolonged capillary refill) despite fluid boluses
4. PH < 7.2 or BE > 6 mmol/l on 2 occasions or associated with signs of shock

### D. Disability
1. Acute deterioration in conscious level
2. Convulsion unresponsive to Lorazepam / Diazepam and second line and consultant (lasting > 10 mins)
3. GCS < 11 or responding only to pain

### E. Others
1. Abnormal lab values - INR > 4 or INR > 6.0 or INR > 2.5
2. Any child with suspected meningococcal
3. Any child whose condition is worrying
Analysis

- Undertaken on each criterion and reviewing it against the patient outcome

- Decision made whether to retain or remove
Figure 1  Distribution of age categories.

Figure 2  Total number of patient triggers by ward (n = 360).

Figure 3  Highest level of care reached by each of the 360 patients.
Research Study

Analysis

Table 1  Ward by ward review of admissions, bed occupancy and patients entered into the study.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of admissions</th>
<th>Number of patients who triggered</th>
<th>Bed occupancy (bed days/6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td>247</td>
<td>24</td>
<td>2342</td>
</tr>
<tr>
<td>BMT</td>
<td>30</td>
<td>22</td>
<td>774</td>
</tr>
<tr>
<td>Cardiac</td>
<td>371</td>
<td>78</td>
<td>1980</td>
</tr>
<tr>
<td>Medical</td>
<td>456</td>
<td>118</td>
<td>2859</td>
</tr>
<tr>
<td>Observation</td>
<td>672</td>
<td>14</td>
<td>280</td>
</tr>
<tr>
<td>Oncology</td>
<td>110</td>
<td>22</td>
<td>1521</td>
</tr>
<tr>
<td>Renal</td>
<td>160</td>
<td>25</td>
<td>1272</td>
</tr>
<tr>
<td>Short stay</td>
<td>538</td>
<td>5</td>
<td>444</td>
</tr>
<tr>
<td>Surgery</td>
<td>681</td>
<td>55</td>
<td>2888</td>
</tr>
<tr>
<td>PICU</td>
<td>393</td>
<td>n/a</td>
<td>2169</td>
</tr>
<tr>
<td>Total</td>
<td>3658</td>
<td>360</td>
<td>16529</td>
</tr>
</tbody>
</table>

- Modified Tool 99% sensitivity & 66% specificity
## Bristol Paediatric Early Warning (PEW) Tool

<table>
<thead>
<tr>
<th>A</th>
<th>Airway obstruction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child has required nebulised adrenaline</td>
</tr>
<tr>
<td></td>
<td>Clinically tiring or impending complete airway obstruction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Breathing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SPO2 &lt; 90% in any amount of oxygen</td>
</tr>
<tr>
<td>2</td>
<td>SPO2 &lt; 75% in any amount of oxygen (congenital heart disease)</td>
</tr>
<tr>
<td>3</td>
<td>Persistent tachypnoea (HR &gt; 70 under 6 months; &gt; 60 6–12 months; &gt; 40 1–5 years; &gt; 35 over 5 years)</td>
</tr>
<tr>
<td>4</td>
<td>Apnoeas or bradycardia (HR &lt; 80 in children; HR &lt; 100 in 1–5 years)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Circulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Persistent tachycardia following one bouts of 10ml/kg fluid: HR &gt; 150 under 5 years, HR &gt; 120 5–12 years, HR &gt; 100 over 12 years</td>
</tr>
<tr>
<td>2</td>
<td>Signs of shock: e.g. prolonged capillary refill &gt; 3s, poor perfusion, low BP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>GCS &lt; 11 or unresponsive or responding only to pain</td>
</tr>
<tr>
<td>2</td>
<td>Convulsion unresponsive to anticonvulsant therapy (lasting &gt; 30 sec)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hyperkalaemia: K+ &gt; 6.0 mmol/l</td>
</tr>
<tr>
<td>2</td>
<td>Any child with suspected meningitis</td>
</tr>
<tr>
<td>3</td>
<td>Any child with diabetic ketoacidosis (DKA)</td>
</tr>
<tr>
<td>4</td>
<td>Any child whose clinical condition is worsening</td>
</tr>
</tbody>
</table>
Implementation...

- New paediatric observation chart
- Multi-professional staff education
- Establishment of a ‘Paediatric Critical Care Outreach Team’
United Bristol Healthcare NHS Trust
Bristol Royal Hospital for Children

**PAEDIATRIC OBSERVATION CHART**

**ADDRESS/LABEL**
- **Name:** Mlle [Name]
- **Date of Birth:** 9.3.04
- **Hospital No.:** 13456789
- **Unit:** Paediatrics

**Patient Information**
- **Weight:** 8.5 kg
- **Height:** 95 cm

**PAIN ASSESSMENT TOOLS USED**
- FACES (Face, Legs, Activity, Cry, Consolability)
- Wong-Baker FACES (0-10)

**NORMAL RESPIRATORY RATE**
- If breathing is not observed, keep the child quiet and record the respiratory rate.

**RESPIRATORY RATE**
- Baby: 30-60
- Toddler: 20-30
- Child: 15-20
- Teen: 12-15

**METHODS OF OXYGEN ADMINISTRATION**
- **Method:** Mask, Venturi Mask, Non-rebreather Mask

**NEUROLOGICAL ASSESSMENT**
- **APGAR**
- **Score:** 1

**PAIN MANAGEMENT**
- **Consider the following:**
  - **Increasing Pain:**
    - Severe: Paracetamol + NSAID + Morphine (PCA / NCA or epidural)
    - Moderate: Paracetamol + NSAID + Codeine
    - Mild: Paracetamol + NSAID
  - **Slight Pain:**
  - **No Pain:**

**MONITORING**
- **Equipment:** Pulse Oximeter, Blood Pressure Monitor, Temperature Monitor

**PAIN SCORE**
- **0:** No Pain
- **1:** Mild Pain
- **2:** Moderate Pain
- **3:** Severe Pain

**SEDATION**
- **0:** None
- **1:** Light
- **2:** Moderate
- **3:** Deep

**NAUSEA / VOMITING**
- **0:** None
- **1:** Mild
- **2:** Moderate

**PRURITUS**
- **0:** None
- **1:** Mild
- **2:** Moderate

**MOTOR BLOCK**
- **0:** Normal
- **1:** Hypotonic
- **2:** Hypertonic

**Support Information / Updates**
- Contact the Pain Service website, 111, Intensive Care Unit

**Remember to reassess pain regularly**
- Check the record of pain assessment:
- **True**
- **False**
- **Improvement**
- **Worsening**
- **Document findings, actions and re-evaluate**
**PAEDIATRIC EARLY WARNING (PEW) TOOL**

**A. ACUTE AIRWAY OBSTRUCTION**
1. Child has required intubation/airway.
2. Clinically tiring or impending complete airway obstruction.

**B. BREATHING**
1. Respirations ≥ 50% higher than normal for age.
2. SPO2 ≤ 95% in any amount of oxygen (pneumonia, heart disease).
3. Persistent cyanosis (RR 570 under 5 months; 60 – 55 under; 60 – 5 yrs; ≥ 55 over 5 yrs).
4. Apnoea or bradycardia (RR ≤ 65 in children under 2 yrs).

**C. CIRCULATION**
1. Persistent tachycardia following use of fluids/medication.
   - (HR ≥ 180 under 5 yrs; HR ≥ 120 5 – 17 yrs; HR ≥ 100 over 12 yrs)
2. Signs of shock: C2P: lack of capillary refill (≤ 3 secs); poor peripheral +/− low BP.

**D. DISABILITY**
1. GCS ≤ 11 or unresponsive, no response to pain.
2. Convulsions or unconsciousness.

**E. OTHERS**
1. Hypoglycaemia - K+ ≤ 4.0 mmol/litre.
2. Any child with suspected meningococcal.
3. Any child with diabetic ketoacidosis (DKA).
4. Any child whose condition is worsening.

**Action to be taken if above tool triggers:**

If a child fits any of the above criteria, seek immediate advice from one or more of the following personnel:

- Senior Nursing Staff on Ward
- SHO / SpR or Consultant of the child's medical team
- RMO
- Nursing Support Team
- Senior Medical or Nursing Staff on Paediatric Intensive Care
- Emergency Call / Cardiac Arrest Call: 222

If there is any delay in obtaining assistance, the child is deteriorating, immediately call all of the above.

If the child already recognizes the above criteria, please document stated acceptable Paediatric Early Warning parameters.

\[ S1 = \frac{C_{O_2}}{P_{O_2}} \leq 0.4 \text{ in any } O_2 \]

Medical signature, date & time:

**Contact Details:**
- SHO / SpR: Name: ___________________________ Bleep No: ___________________________
- Consultant: Name: ___________________________ Pager / Bleep No: ___________________________
- RMO: Bleep No: ___________________________
- Outreach Nurse / Team: Bleep No: ___________________________
- Paediatric Intensive Care Unit Fax: 6546 / 6437 Emergency phone number: Cardiac arrest call: 222
Paediatric Critical Care Outreach Team

- Commenced September 2004
- 5.3wte until April 2005 – then review (permanent team 2.2wte)
- Team comprises senior paediatric nurses with acute paediatric background (primarily PIC)
- Initial cover 0730-2130 (some transient night cover – flexible to demand)
- Winter cover 24hr/day – 7 days/wk
Paediatric Critical Care Outreach Team—Achievements to date.....

Key work:

- Implementation / Education around PEW
- Provide direct clinical assessment / support for ward areas
- CPAP / NIV / Sleep Studies / LTV children to ward areas
- Children requiring low dose inotropes to cardiac ward
- Development of local high dependency guidelines for practice
  - Insitilation of Urokinase into chest drains
  - Use of CPAP drivers / Vapotherm system
  - 12 lead ECG’s

- Education for ward areas – study modules / direct clinical support for staff
- Follow-up of all children discharged from PIC for 48 hrs
  - Transitional care issues
Can Paediatric Outreach Contribute to the Delivery of HDU Services?

**Pro’s**
- Enhance quality of care for acutely ill children in ward areas
- Support staff on wards
- Enhanced confidence of staff when caring for acutely ill children
- Enhance knowledge and skills of ward based staff
- Reduce PICU admissions
- Reduce child & family stress from being discharged from PICU
- Reduce hospital stay for children

**Con’s**
- Needless resource – expertise of staff should already be present
- Deskilling of staff
- Perception of PICU wanting to ‘rule the world’!
Evaluation....

- Anecdotal
- Type of children now admitted to ward areas
- More timely admissions to PIC – audit
- Cost issues ....
- Evidence needed – proving difficult to obtain in adults, assume same in children
  - Staff attitudes
  - Critical Incident monitoring
  - Reduced cardiac arrests
  - Monitor use of team
  - Reduced admissions to PICU
Current & Future Development

- Database ... 1st July 2007
- Extended links between medical & nursing personnel – day & night

September 2007

- Combining Critical Care Outreach & Clinical Co-ordinating Team = Clinical Site Team
- x2 senior paediatric nurses – 24hrs/day x 7days/wk + medical cover
- Develop advanced skills of nursing staff
- Involve multi-professionals in Team
Conclusion...

1 system does not work for all .....  

- Tertiary Children’s Hospital’s without HDU  
- Tertiary centres with HDU  
- District General Hospitals  
  - With dedicated HDUs  
  - With HDU in ward areas

Each hospital needs to focus on their own service, need, existing facilities & support services, & develop a system that addresses their own safety & quality challenges ..
The deterioration of children in ward areas in a specialist children’s hospital

Lyamome Tume

ABSTRACT
Educational and research activities in the intensive care and high-dependency units at children’s hospitals are underpromoted. However, many of these nurses often lack the demonstrable documentation required to make decisions, which can be critical in the decision-making process. The aim of this research was to evaluate the extent of documentation and assess its impact on nurses within a dedicated hospital ward in the North West of England, using a self-reporting tool. The results indicate a strong preference for clinical documentation. This supports the evidence that there is considerable documentation required to support decision-making in a range of educational and research settings. The study aimed to explore whether documentation is adequate, and whether it assists in the decision-making process. The findings suggest that documentation is inadequate, and further research is required to improve the quality of documentation.
Can Paediatric Early Warning Assessment Tools Assist in Delivering Quality Care for Hospitalised Children?

WE BELIEVE SO!
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