Policy Compliance Procedure

Infants and Children – Acute Management of Bronchiolitis

Sites where PCP applies

This PCP applies to:

1. Adults	No
2. Children up to 16 years	Yes
3. Neonates – less than 29 days	Yes
Target audience	Clinicians in ED where infants and children present who cough, wheeze and shortness of breath.
Description	Provides evidence based practice guidelines for the treatment of infants with bronchiolitis.

Hyperlink to Procedure

Keywords	Infants, acute management, emergency department
This PCP relates to NSW Ministry of Health Policy Directive	NSW PD2012_004 Infants and Children – Acute Management of Bronchiolitis
Document Registration Number	PD2012_004: PCP1
Replaces existing document?	Yes
Document number and dates of superseded document/s	PD2012_004: PCP1 Version One from 20 March 2012

Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:

- PD2012_004 Infants and Children with Bronchiolitis
- http://www.health.nsw.gov.au/policies/pd/2012/PD2012-004.html

Tier 2 Director responsible for Policy to which the PCP relates. PCP authorised by	Professor Trish Davidson, Director Children, Young People and Families
PCP contact person and Network or Service etc. responsible for the PCP	Rhonda Winskill, Paediatric Rural Outreach CNC, HNE LHD/Northern Child Health Network.
Contact details	Mobile: 0438 809 688
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This document contains advice on therapeutics	No
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TRIM number	15/43-2-10

Note: Over time links in this document may cease working. Where this occurs please source the document in the PPG Directory at: http://ppg.hne.health.nsw.gov.au/

RISK STATEMENT

This PCP has been developed to provide user friendly, current clinical practice guidelines for clinical staff in the assessment, management and discharge planning of infants and children with bronchiolitis. Non-compliance to this PCP may result in infants with bronchiolitis receiving clinical care that is not based on best practice guidelines.
Risk Category*:* Clinical Care & Patient Safety

GLOSSARY

Acronym or Term	Definition
BSL	Blood sugar level
CXR	Chest X-Ray
CPAP	Continuous Positive Airway Pressure
IV	Intravenous
NBM	Nil by mouth
NETS	NSW Newborn & Paediatric Emergency Transport Service
NG	Naso-gastric tube
PICU	Paediatric Intensive Care Unit

PROCEDURE

Compliance with this PCP is mandatory.

IMPLEMENTATION AND MONITORING COMPLIANCE

This PCP establishes evidenced based best practice for HNE LHD consistent with PD2012_004 which requires mandatory compliance. The PCP will be implemented in all HNE LHD Emergency Departments and compliance monitored with IIMS.

FEEDBACK

Any feedback on this document should be sent to the Contact Officer listed on the front page.

Assessment and Initial Management

Reconsider diagnosis if the child is >1 year, looks "unwell", has a high fever or responds poorly to treatment.

Initial Severity Assessment Treat in the highest category in which any symptom occurs			
Symptoms	**Mild**	**Moderate**	**Severe and Life Threatening**
Appearance	Well	Mildly Unwell	Unwell
Respiratory Rate*	Mild Tachypnoea	Moderate Tachypnoea	Apnoeas Severe Tachypnoea Greater than 70 Bradypnoea less than 30
Work of Breathing	Normal	Mild to Moderate	Moderate to Severe Grunting
Cyanosis	No Cyanosis	No Cyanosis	May be Cyanosed or Pale
Oxygen Saturation **Oxygen Requirement**	Above 95% in Air	90 - 95% in Air	Less than 90% in Air Less than 92% in O_2
Heart Rate	Normal	Mild Tachycardia	Marked Tachycardia 180
Feeding	Normal or slightly Decreased	Difficulty feeding but may be able to take more than 50% of normal feed	Difficulty feeding taking less than 50% of normal feed
		Contact Paediatrician	**Get senior help then call NETS 1300 36 2500**
TREATMENT			
Oxygen	No	Give O_2 to maintain saturation at or above 95% and/or to improve work of breathing	Maintain oxygen saturation at greater than 95% Ensure high inspired oxygen via high flow delivery device if required
Hydration	Recommend smaller more frequent feeds if required	Smaller more frequent feeds Consider NG feeds	IV* fluids and NBM
Investigations	Nil required	Nil required	Consider – CXR and Blood Gas / BSL
Observation & Review	Hourly	Continuous SaO_2 monitoring Minimum hourly observation	Continuous cardio respiratory and SaO_2 monitoring – Constant observation
No or Poor response to Treatment		Check diagnosis Escalate treatment	Get Senior Help Consult PICU via NETS Consider CPAP May need intubation
Disposition	Likely to go home	Likely to admit Decision around hospitalisation of infants with SaO_2 between 92% & 95 % should be supported by clinical assessment, phase of the illness & social & geographical factors	Transfer to an appropriate paediatric unit via NETS If in a children's hospital may need PICU

*** If IV fluids are clinically indicated discuss IV fluid rate/fluid type with Paediatrician/Senior Emergency Physician. BEWARE: Fluid overload, pulmonary oedema, hypoglycaemia.**

*** For a single reported apnoea before presentation admit for observation and treat as moderate.**

FACT SHEET: See www.kaleidoscope.org.au