Policy Compliance Procedure

Health
Hunter New England Local Health District

Recognition of a Sick Baby or Child in the Emergency Department

This PCP relates to NSW Health Policy Directive	NSW PD 2011_038: Recognition of a Sick Baby or Child in the Emergency Department
PCP number	NSW PD 2011_038: PCP 1

Sites where PCP applies	All HNE Health Emergency Departments (ED)
Target audience	Clinicians in ED where infants and children present
Subject	Recognition of a Sick Baby or Child in the Emergency Department
Keywords	Recognition, Sick Baby, Sick Child, Emergency Department
Replaces existing PCP	Yes
Document number and/or name of superseded document/s	PD2005_382:PCP 5, PD2005_382:PCP 3 PD2005_382:PCP 1, PD2005_382:PCP 2, PD2005_382:PCP 6 from May 2007

Related Legislation (including OHS legislation), Australian Standards, NSW Health Policy or Circular, NSQHS Standard/EQuIP Criterion, other HNE Health Documents, Professional Guidelines, Codes of Practice or Ethics::

- NSW Health Paediatric Clinical Practice Guidelines
  http://www0.health.nsw.gov.au/policies/groups/ps_baby.html

Tier 2 Director responsible for Policy	Professor Trish Davidson, Clinical Leader, Children, Young People and Families Clinical Network
Policy Compliance Procedure Contact Position and Network or Service etc. responsible for the PCP	Helen Stevens, Paediatric Clinical Nurse Consultant, HNE Health / Northern Child Health Network
Contact Details	Helen.stevens@hnehealth.nsw.gov.au Mobile phone: 0428 263 809 Ph: 6776 9806

Summary

- The aim of this PCP is to provide assistance to clinicians to appropriately recognise the acuity of a baby or child presenting, and subsequently inform the triage process.
- Fact sheet for parent information is available at www.kaleidoscope.org.au

To be distributed to:	General Managers, DON, Paediatricians, NUM ED, ED Physician, Director of Medical Services CYP&FCN Stream Leaders
Date authorised:	5 April 2013
Authorised by:	Professor Trish Davidson, Clinical Leader, Children, Young People and Families Clinical Network
Date of Issue:	21 May 2013
Review Date:	21 May 2016
TRIM Number:	13/55-2-26

Health
NSW GOVERNMENT Hunter New England Local Health District

Recognition of the Sick Child

A heightened level of concern should be applied to all infants < 3 months seek paediatric advice

Any child who re-presents with the same or similar illness within 24 hours to an Emergency Department should not be discharged before being seen by an appropriate specialist registrar or GP VMO. This may require an overnight admission.

AIRWAY	BREATHING	CIRCULATION	DISABILITY /LOC/PAIN	FLUIDS IN/ FLUIDS OUT	ACTION
Obstructed **Partially obstructed with increased effort of breathing**	▪ Recent or current apnoea or abnormally slow breathing ▪ Severely increased effort of breathing - With severe tachypnoea*, accessory muscle use, recessions, nasal flaring, grunting and/or gasping. **NOTE:** above signs can be absent in ▪ Exhaustion ▪ Central respiratory depression ▪ Neuromuscular problems - Reduced or asymmetric chest expansion - Absent breath sounds ▪ SpO_2 less than 90% in any amount of O_2 ▪ Cyanotic	▪ Cardiac arrest ▪ Severe tachycardia* ▪ Peripheral pulse absent or weak ▪ Bradycardia less than 60* ▪ Uncontrolled bleeding ▪ Central capillary refill over 4 seconds ▪ Hypotension*	▪ Unresponsive ▪ Responds only to pain ▪ Severe Pain : Pain score 7 – 10 ▪ Seizure ▪ Paralysis	▪ No urine output 24 hours ▪ Hyperglycaemia (BGL greater than 12mmol/L) ▪ Hypoglycaemia (BGL < 2mmol/L or symptomatic) ▪ Severe dehydration	▪ Requires immediate response (refer to local escalation protocol) ▪ Continuous monitoring (HR, ECG, SpO_2 + frequent BP + RR) ▪ Continuous clinical observation ▪ Discuss with Paediatrician or NETS (Tel: 1300 36 2500) regarding management and need for transfer
Partially obstructed + normal effort of breathing	▪ Moderately increased effort of breathing - With moderate tachypnoea*, moderate accessory muscle use, recession, nasal flaring - SpO_2 90% - 94% in room air	▪ Moderate tachycardia*, ▪ Pallor ▪ Central capillary refill 3-4 seconds ▪ Skin mottled, cold ▪ Hypotension*	▪ Responds only to voice ▪ Poor response to environment ▪ Moderate pain : pain score 4-6 ▪ Recent seizures ▪ Parasthesia ▪ Weak cry ▪ Irritability or Agitation	▪ Moderate dehydration ▪ Vomiting - Bile - Coffee ground - Blood - Greater than 6 in 12 hours ▪ Melaena or red currant jelly stool ▪ Hyperglycaemia (BGL 9-12mmol/L) ▪ Hypoglycaemia (BGL 2-3mmol/L)	▪ A clinical review by an experienced clinician is required within 30 minutes (refer to local protocol) ▪ Continuous monitoring ▪ Consider need for transfer and discuss with senior clinician or NETS ▪ If clinical review is not undertaken within 30 minutes and the condition is not resolved, escalate call to rapid response (refer to local protocol)
Patent	▪ Mildly increased effort of breathing with mild tachypnoea* ▪ SpO_2 over 94% in room air ▪ Pink	▪ Mild tachycardia* ▪ Normotensive ▪ Capillary refill (less than 3 seconds)	▪ Alert but with decreased activity ▪ Mild pain: Pain score 1-3 ▪ Prolonged sleeping	▪ Mild dehydration ▪ Less than 50% of normal fluid intake ▪ Urine volume reduced ▪ Vomiting - non-bilious - less than 6 in 12 hours	▪ Increase frequency of observations (refer to the SPOC) Initiate appropriate clinical care

RISK FACTORS: CONSIDER AS MORE URGENT

SPECIFIC PROBLEMS

- High risk Mechanism of Injury
- Rash: Petechial, non-blanching, allergic
- Testicular pain (surgical review)
- Chemical exposure / envenomation / ingestion (Contact the NSW Poison Information Centre 131126
- Severe burns
- Mental health presentation

AGE

- **Less than 3 months**

A heightened level of concern should be applied to ALL infants less than 3 months and advice from a Paediatric Clinician should be sought

ALSO CONSIDER

- Disease dynamic – how long has the child been unwell; what has occurred prior to presentation (symptoms and pre hospital treatment eg antipyretics, sedating agents
- Parental concern – what are the parents saying?
- Co-morbidity– prematurity or chronic illness
- Immuno-compromised
- Recent admission to hospital
- Multiple presentations with same illness

*** Colour coding on this table corresponds with colour coding on the Standard Paediatric Observation Chart**
Only one symptom is required for a higher urgency category to be allocated

Health
NSW GOVERNMENT Hunter New England Local Health District

Recognition of the Sick Neonate

A heightened level of concern should be applied to all infants < 1 month seek paediatric advice

Any child who re-presents with the same or similar illness within 24 hours to an Emergency Department should not be discharged before being seen by an appropriate specialist registrar or GP VMO. This may require an overnight admission.

AIRWAY	BREATHING	CIRCULATION	DISABILITY /LOC/PAIN	FLUIDS IN/ FLUIDS OUT	ACTION
Obstructed **Partially obstructed with increased effort of breathing**	▪ Recent or current apnoea or abnormally slow breathing ▪ Severely increased effort of breathing - With severe tachypnoea*, accessory muscle use, recessions, nasal flaring, grunting and/or gasping. **NOTE:** above signs can be absent in - Exhaustion - Central respiratory depression - Neuromuscular problems ▪ Reduced or asymmetric chest expansion ▪ Absent breath sounds ▪ SpO_2 less than 90% in any amount of O_2 **Or** requirement for more than 60% oxygen ▪ Cyanotic or extreme pallor ▪ Need for CPAP or IPPV	▪ Cardiac arrest ▪ Severe tachycardia* ▪ Peripheral pulse absent or weak ▪ Bradycardia* ▪ Uncontrolled bleeding ▪ Central capillary refill over 4 seconds ▪ Hypotension*	▪ Unresponsive ▪ Unconscious ▪ Seizure	▪ No urine output 24 hours ▪ Hyperglycaemia (BGL greater than 12mmol/L) ▪ Hypoglycaemia (BGL < 1.7mmol/L) ▪ Severe dehydration ▪ Weight loss greater than 15% birth weight	▪ Requires immediate response (refer to local escalation protocol) ▪ Continuous monitoring (HR, ECG, SpO_2 + frequent BP + RR) ▪ Continuous clinical observation ▪ Discuss with Paediatrician or NETS (Tel: 1300 36 2500) regarding management and need for transfer
Partially obstructed + normal effort of breathing **Secretions needing suction**	▪ Moderately increased effort of breathing - With moderate tachypnoea*, moderate accessory muscle use, recession, nasal flaring, intermittent grunting in a newborn - SpO_2 90% - 94% in room air or requirement for more than 40-60% oxygen Abnormal pattern of breathing	▪ Moderate tachycardia*, ▪ Pallor ▪ Central capillary refill 3-4 seconds ▪ Skin mottled, cold ▪ Hypotension*	▪ Hypotonic / hypertonic ▪ Poor feeding/suck ▪ Excessive crying ▪ Poor response to the environment ▪ Recent seizures ▪ Weak cry or irritable high pitched cry ▪ Irritability	▪ Moderate dehydration ▪ Weight loss of 10-14% birth wt ▪ Reduced number of wet nappies ▪ Markedly reduced volume and timing of feeds ▪ Vomiting - Bile / Blood / Coffee ground ▪ Melaena or red currant jelly stool ▪ Hypoglycaemia (BGL 1.7 – 2.5mmol/L)	▪ A clinical review by an experienced clinician is required within 30 minutes (refer to local protocol) ▪ Continuous monitoring ▪ Consider need for transfer and discuss with senior clinician or NETS ▪ If clinical review is not undertaken within 30 minutes and the condition is not resolved, escalate call to rapid response (refer to local protocol)
Patent	▪ Mildly increased effort of breathing with mild tachypnoea* ▪ SpO_2 over 94% in room air ▪ Pink	▪ Mild tachycardia* ▪ Normotensive ▪ Capillary refill (less than 3 seconds)	▪ Alert but quiet ▪ Prolonged sleeping	▪ Mild dehydration ▪ Weight loss up to 9% birth wt ▪ Mild reduction in volume and time of feeds ▪ Increased milk vomits	▪ Increase frequency of observations (refer to the SPOC) Initiate appropriate clinical care

RISK FACTORS: CONSIDER AS MORE URGENT

SPECIFIC PROBLEMS

- Maternal history or peripartum herpes, chorioamnionitis, fever, prolonged rupture of membranes (greater than 18 hours), group B strep colonisation
- Perinatal and post natal complications
- Heart murmur/non palpable femoral pulses
- Dysmorphic features / Family History of childhood disease or consanguinity
- Bloated abdomen
- Umbilical discharge, redness or infection
- Skin infections

TEMPERATURE

- Hypothermia

AGE

- All patients less than one month

ALSO CONSIDER

- Disease dynamic – ante natal and family history; how long has baby been unwell
- Parental concern – what are the parents saying?
- Co-morbidity– prematurity or congenital conditions
- Immuno-compromised - prematurity
- Recent admission to hospital or multiple presentations
- Maternal health - consider PND, drug and alcohol problems
- Neonates presenting with jaundice –check and plot bilirubin levels

*** Colour coding on this table corresponds with colour coding on the Standard Paediatric Observation Chart**
Only one symptom is required for a higher urgency category to be allocated