Policy Compliance Procedure

Deteriorating Paediatric Patient - Recognition and Management– Excluding Critical Care Areas

Sites where PCP applies	All areas where paediatric patients are treated within Hunter New England Local Health District (HNELHD). **Excluding**: Neonatal Intensive Care Unit (NICU)/Special Care Units (SCU) and Paediatric Intensive Care Unit (PICU).
Adults	No
Children up to 16 years	Yes
Neonates – less than 29 days	Yes
Target audience	All clinical staff providing care to paediatric patients.
Description	Outlines the management of patients who are clinically deteriorating and the essential elements of care staff are required to provide to all patients.

Go to Procedure

National Standards V2	1, 8
Keywords	CERS, deterioration, Between the Flags, SPOC, PEDOC, paediatric, children, observations, resuscitation trolley, emergency equipment check, core, rapid response, clinical review
This PCP relates to NSW Ministry of Health Policy Directive	NSW Health PD2020_018 Recognition and Management of Patients who are Deteriorating.
PCP number	PD2020_018:PCP 12
Replaces existing document?	Yes. JHCH 3.19 Recognition of the Deteriorating Paediatric Patient

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

- NSW Health PD2020_018 Recognition and management of patients who are deteriorating.
- HNELHD PD2020_010:PCP 1: Recognition and Management of Patients Who Are Clinically Deteriorating
- Australian Commission on Safety and Quality in Health Care. (2010). National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration in Acute Health Care. Sydney, ACSQHC. Retrieved January 2017

Tier 2 Director responsible for Policy to which the PCP relates. PCP authorised by	Paul Craven, Executive Director Children, Young People and Families Services
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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/

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    d) Roles & responsibilities
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3. Sepsis Kills
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RISK STATEMENT

This policy compliance procedure has been developed to provide direction to staff and to ensure paediatric patients at risk of deterioration are recognised and managed. Failure to recognise and respond to a deteriorating patient may result in an adverse event and unintended patient harm.

Risks will be managed when clinicians:

1. Conduct a patient assessment including a full set of observations at least every 4 hours (unless the altered calling criteria has been documented)
2. Utilise approved track and trigger Standard Paediatric Observation Charts (SPOC) or Paediatric Emergency Department Observation Charts (PEDOC) to record vital sign observations
3. Increase the frequency of observations and initiate appropriate clinical care when a patient's observations are outside the White Zone on the Standard Observation Charts
4. Respond appropriately to and/or escalate care as per local Clinical Emergency Response Systems (CERS) when observations breach Blue, Yellow and Red Zones or when additional calling criteria are triggered
5. Document actions taken in the patient's health care record

Risk Category*:* Clinical Care and Patient Safety

PROCEDURE

Compliance with this PCP is mandatory.

Staff are directed to escalate care if they, or a parent/carer is worried, regardless of the observations. The SPOC/PEDOC provide a framework to assist in the recognition of deterioration but do not negate clinical judgement or intuition.

CLINICAL PROCESSES

Measurement and Recording of Observations

It is essential that all paediatric patients have physiological core observations monitored and documented regularly.

Acute care setting:

- Undertake observations and an initial assessment at the time of admission to the ward.
- Record in the medical and nursing admission documentation which forms part of the child's health care record, and on an age-appropriate SPOC/PEDOC.
- Obtain vital sign observations six times per day at fourth hourly intervals on every child.

Variation of observations:
Patients under the care of a specialist team may have this frequency modified following clinical assessment by the relevant medical officer AND

- Document on the front page of the current observation chart.
- Review variation in frequency at least every 48 hours.

Minimum core observations include: temperature (T), pulse (P), respiratory rate (Resp Rate), Respiratory distress (Resp Distress), oxygen saturation (SpO_2), pain assessment, level of consciousness (LOC) using Glasgow Coma Score (GCS) or Alert, Voice, Pain, Unresponsive (AVPU) and any new onset confusion or behaviour change*.

The requirements for obtaining blood pressures in children are:

- As soon as practicable in all Australian Triage Scale (ATS) 1 and 2 patients.
- On admission to the ward.
- When other observations are in the Yellow or Red Zone.
- Pre transfer to the ward from PICU and Post Anaesthetic Recovery Unit.
- Pre and post clinical interventions e.g. sedation, surgery.

Observations must be plotted as trended data on an age-appropriate SPOC/PEDOC, with the times entered as the observations are completed. Each entry must be signed by the staff member documenting the observations.

With one exception: Female young people **≥ 14 weeks gestation** must have their observations recorded on a **Standard Maternity Observation Chart (SMOC)**. Female young people under 14 weeks gestation must have their observations record on a SPOC chart. SMOCs can be obtained from the maternity wards.

DETERIORATION IN MENTAL STATE

The current definition is: A negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state.
Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to Recognition and management of patients who are deteriorating several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.

***Mental State Assessment:** Includes an assessment of the patient's behaviour in the context of their developmental age and/or baseline assessment, noting changes in their cognitive function, activity/tone, perception, or emotional state such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.

If a change in mental state is detected, contact the treating medical team or follow the local CERS.

A formal change on the SPOC/PEDOC will occur to include mental state deterioration in 2021.

Frequency of Observations

The frequency of observations will depend on the clinical situation of the patient which should be described in the health care record. The following guide should be used as a minimum requirement in the varying specific situations:

Additional Risk of Deteriorating	Hourly (or as stipulated)	Fourth Hourly	Daily
Insulin Infusion	Blood glucose level (BGL), insulin infusion, pain assessment.	T, P, Resp Rate, GCS or AVPU	B.P Weight
Neurological	Neurological assessment (GCS or modified GCS), P, Resp Rate, SpO_2, pain assessment.	T	B.P
Neurovascular	Neurovascular assessment and pain assessment for twenty-four hours, then fourth hourly.	T, P, Resp Rate, GCS or AVPU	B.P
Oxygen Therapy	P, Resp Rate, SpO_2, gas flow, Resp Distress, pain score, GCS or AVPU.	T	B.P
Post-ICU Transfer	T, P, R, B.P., SpO_2, Resp Distress, pain assessment and level of consciousness (LOC) – GCS or AVPU on arrival to ward and hourly for 4 hours, then second hourly for eight hours unless otherwise documented. An initial falls and Glamorgan Pressure Injury Risk Assessment should also be attended.	T, P, Resp Rate, B.P., SpO_2, pain assessment, GCS or AVPU after 12 hours if stable	Consider weight, BGL
Post-Procedure on Ward	Core observations: T, P, Resp rate, B.P., Resp Distress, SpO_2, sedation assessment, pain assessment, GCS or AVPU and wound assessment initially. Then hourly for four hours on return to ward, then routine fourth hourly.		
Sedation	Core observations: T, P, Resp rate, B.P., Resp Distress, SpO_2 and GCS or AVPU, then 5-10 minutely P, R, SpO_2 during sedation and recovery period, then hourly P, R, with continuous SpO_2, and sedation assessment until GCS or AVPU, LOC returns to baseline. Also attend pain		

	assessment with all observations if child is sedated for a painful procedure.		
Post Rapid Response Team Review	Core observations continuous monitoring T, P, Resp Rate Resp, distress and SpO_2. Documentation with each action of the team. Neurological assessment (GCS or modified GCS), every 15-30 minutes. B.P and pain score attended as clinically indicated. **Then follow Red Zone minimum requirements for observations as per local CERS.**		
Post Clinical Review	Core observations repeated within 30 minutes. **Then follow Yellow Zone minimum requirements for observations as per local CERS.**		

ALTERED CALLING CRTIERIA

Refer to 'Altering Calling Criteria on Standard Observation Charts' – also see HNELHD Altering Calling Criteria on Standard Observation Charts.

Changes made to the standard calling criteria by the AMO/delegated clinician responsible, to take account of a patient's unique physiological circumstances and/or medical condition. Alterations may be 'acute' or 'chronic'.
Standard calling criteria (blue, yellow or red zone parameters) may be altered and/or other agreed signs of deterioration identified, based on assessment of the patient's condition and with input from patients, carers and families.
A medical officer may alter the standard calling criteria following assessment of the patient and engagement of patients, carers and families, and in consultation with the AMO/delegated clinician responsible.
Patients with acute alterations to calling criteria must have daily medical reviews to ensure their clinical progress aligns with the patient's treatment plan.

An **'acute'** alteration may be set to align the calling criteria with the expected progression of a patient's disease or condition. Acute alterations are set for a defined period of time, not longer than 8 hours, before reverting back to the standard calling criteria on the appropriate standard observation chart.
Special treatment plans, such as a Resuscitation Plan, which may also alter the response to the red and yellow zone triggers, are to be documented in the patient's health care record.

A **'chronic'** alteration may be set to align the calling criteria with the patient's baseline vital sign observation parameters. A chronic alteration may be set for the duration of the patient's episode of care and needs to be formally reviewed by the clinical team responsible for the patient's care during routine assessments. A chronic alteration may be set for patients treated in non-hospital or residential care settings, however time limits for the duration of the alteration must be set at the time the alteration is ordered and documented in the patient's medical record.

ESCALATION PROTOCOL - CLINICAL ESCALATION RESPONSE SYSTEM (CERS)

When patient's observations fall into the Blue, Yellow or Red Zones, an increase in the frequency of observations is required. Refer to your facility's Paediatric CERS.

Once the patient has been stabilised observations are to continue.
When the patient falls into a different Zone (on the SPOC) than the last set of observations, repeat and document the observations within 15 minutes to determine if there is deterioration or an abnormality.

If observations are documented in the Blue Zone on the SPOC,

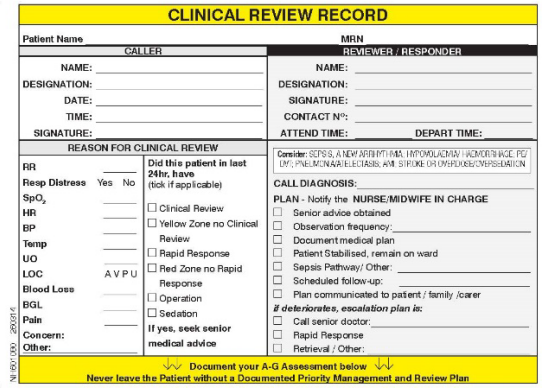
- Notify the nurse in-charge.
- Increase the frequency of the observations e.g. if on fourth hourly observations, repeat observations within an hour.
- Blue Zone must have core observations repeated within an hour.

If observations are documented in the Yellow Zone on the SPOC,

- Notify the nurse in-charge.
- Review the child by the nurse in-charge or call the appropriate resident or registrar to notify the team of the deterioration.
- Document the nurse-in-charge review and decisions on SPOC and in the patient's health care record.
- Repeat and increase the frequency of observations but must have core observations repeated within 30 minutes and post clinical review.
- Together with the nurse/midwife-in-charge or relevant clinical supervisor, consider the following:
    - What is usual for the patient and are there documented alterations to calling criteria?
    - Does the trend in observations suggest deterioration?
    - Is there more than one yellow zone observation or additional criterion?
    - Are you concerned about your patient?

If further escalation is required, when calling the medical officer

- State you have an URGENT CLINICAL REVIEW.
- Document the clinical review time called/notified in the intervention section of SPOC and in the patient health care record using the Clinical Review sticker approved in local facility, (example below, use local where applicable). The patient must be reviewed by a nurse in-charge or a medical officer within 30 minutes
- Document a plan in the notes and/or on the sticker by the staff member attending the review.
- For further information on how to complete the sticker see appendix 1. Other local stickers may used.



CLINICAL REVIEW RECORD

Patient Name MRN

CALLER

NAME:
DESIGNATION:
DATE:
TIME:
SIGNATURE:

REVIEWER / RESPONDER

NAME:
DESIGNATION:
SIGNATURE:
CONTACT N°:
ATTEND TIME: DEPART TIME:

REASON FOR CLINICAL REVIEW

	Yes	No
RR		
Resp Distress		
SpO_2		
HR		
BP		
Temp		
UO		
LOC	A V P U	
Blood Loss		
BGL		
Pain		
Concern:		
Other:		

Did this patient in last 24hr, have (tick if applicable)

- ☐ Clinical Review
- ☐ Yellow Zone no Clinical Review
- ☐ Rapid Response
- ☐ Red Zone no Rapid Response
- ☐ Operation
- ☐ Sedation

If yes, seek senior medical advice

Consider: SEPSIS, A NEW ARRHYTHMIA, HYPOGLAEMIA / HAEMORRHAGE, PE / DVT, PNEUMONIA/ATELECTASIS, AMI, STROKE OR OVERDOSE/OVERSEDATION

CALL DIAGNOSIS:

PLAN - Notify the NURSE/MIDWIFE IN CHARGE

- ☐ Senior advice obtained
- ☐ Observation frequency:
- ☐ Document medical plan
- ☐ Patient Stabilised, remain on ward
- ☐ Sepsis Pathway/ Other:
- ☐ Scheduled follow-up:
- ☐ Plan communicated to patient / family /carer

If deteriorates, escalation plan is:

- ☐ Call senior doctor:
- ☐ Rapid Response
- ☐ Retrieval / Other:

Document your A-G Assessment below
Never leave the Patient without a Documented Priority Management and Review Plan

NHDH1000 29/01/14

If an urgent clinical review or response does not occur within 30 minutes, further escalation MUST occur to a Rapid Response call (see local CERS).

If observations are documented in the Red Zone on the SPOC:

- Assess the situation. Stay with the patient and initiate the appropriate emergency care.
- Notify the Nurse in-charge and relevant medical team/s.
- Another staff member initiates a Rapid Response Call as per facility protocol.
- Complete an A-G assessment, use continuous monitoring and obtain full set of observations **every 5 minutes** until the Rapid Response Team (RRT) arrives, then **repeat observations every 15 minutes** until management plan for the patient is in place.
-
- Notify the admitting medical officer (AMO) for all Rapid Response calls as soon as possible.
- Record minimum core observations: T, P, R, B.P., SpO_2, Resp Distress, pain assessment and level of consciousness.
- Document any abnormal observations or investigations and the clinical response in the patient's health care record
- Consider consultation with a neonatologist or paediatrician for infants aged less than 28 days corrected, if deterioration is detected.
- Display formalised CERS document in areas where all staff can access.

When a RRT call is made, the following is to occur: (also see APPENDIX 4. HNELHD RAPID RESPONSE PROCESS in PCP BTF - Recognition and Management of Clinical Deterioration PD2013_049: PCP 1

- Remain with the patient and call for assistance.
- Request resuscitation trolley to be bought to bedside.
- Communicate to the patient and family (if present) that a rapid response has been called and that more staff will be coming to review the patient and assist if required.
- Request the patient's treating team to attend the rapid response call, if they are not already present (this includes the senior medical officer).
- Provide ISBAR handover to the RRT on arrival.
- Remain with patient until further advised by RRT.
- Partner with the patient, parent or care to discuss and establish a clinical management plan.
- Document individual component of the rapid response, including action and calls in the patient's health care record
- Document clinical review or rapid response incident in IMS+

Rapid Response Team (RRT)

The RRT is triggered by placing a **2222 (or follow CERS protocol)** phone call and requesting a **paediatric rapid response**.
Tell the operator the **location** e.g. facility, ward and bed number or outpatient area.
The criteria for requesting RRT assistance may be any of the following:

- Cardiac arrest
- Respiratory arrest
- Circulatory collapse
- Unresponsive patient
- New onset stridor
- Worried – staff or parents are concerned that the patient may be at risk of serious deterioration.
- Three (3) or more simultaneous observations in the Yellow Zone
- Failure or inability of medical staff to provide a clinical review within 30 minutes of deterioration into the Yellow Zone in the absence of altered calling criteria, and ongoing deterioration (must be reported in IMS+)
- Deterioration not reversed within one (1) hour of clinical review
- Observations falling within the Red Zone on an age-appropriate SPOC in the absence of altered calling criteria
- Significant bleeding
- Sudden decrease in level of consciousness (a drop of 2 or more points in GCS).
- New or prolonged seizure activity
- Floppy
- BGL < 2mmol/L or symptomatic
- Lactate ≥ 4mmol/L

The RRT response will:

- Assess the patient and make a provisional diagnosis of the problem, and have a management plan documented in the patient's health care record
- Undertake appropriate therapeutic interventions
- Attempt to stabilise and maintain the patient
- Have authority to make transfer decisions and access other care providers in order to deliver definitive care

In cases where patients require transfer, clinical staff may be required to assist the RRT in providing safe supportive care whilst awaiting transfer and also assist during the transfer.

TRANSFER PARAMETERS FROM HIGH LEVEL TO LOWER LEVEL OF CARE

Patients should NOT be transferred to a lower or equal level of care whilst observations are in the **Red Zone** unless the following has occurred:

- The senior medical officer from the transferring area is aware of the Red Zone observation/s, has reviewed the patient.
- Notified the receiving paediatric consultant/AMO that the patient is a candidate for transfer but is in the Red Zone for particular observations.

- If the receiving paediatric consultant/AMO disagrees with the plan to transfer the patient, they must discuss the concerns with the most senior medical officer in the transferring area.
- This discussion and outcome MUST be documented in the patient's health care record.

If the paediatric Consultant/AMO agrees with the plan to transfer, the following needs to occur:

- Nurse unit manager (NUM) or nurse-in-charge (NIC) of receiving unit is to be contacted. The NUM/NIC may need to also contact the Nurse Manager on call or after hours manager to discuss the transfer and an agreement reached to ensure patient safety and staffing levels are adequate.
- Altered calling criteria needs to be agreed before transfer and clearly documented on the front of the SPOC and a clear management plan documented in the patient's health care record.
- A management plan of care including a suitable level of medical monitoring needs to be in place before transfer.
- A higher level of escort needs to be provided for the transfer including personnel and equipment.

Patients who are being transported with observations in the **Yellow Zone** in the absence of altered calling criteria must have the following attended PRIOR to transfer:

- A clinical handover of the patient's condition and situation given by the transferring clinicians and accepted by the receiving clinician for both medical and nursing.
- A clearly documented plan of care in the patient's health care record including when the next medical review will occur +/- altered calling criteria on the SPOC.
- Clinical handover to the nurse in-charge of the receiving unit.
- The patient must then be transported with an escort, monitoring and equipment.

The outcomes of all discussions and the resulting decisions must be clearly documented in the patient's health care record.

SEPSIS PATHWAY

Sepsis is one of the leading causes of death in children. Many paediatric sepsis related deaths are preventable. It is widely acknowledged that sepsis can be a difficult diagnosis to make in children and infants. The SEPSIS KILLS Program has developed a number of paediatric tools and resources to assist clinicians in the early recognition, notification, escalation and initial management of sepsis.

HNELHD PCP Recognition and Management of Sepsis PD2013_049:PCP 7

CEC Paediatric Sepsis Kills Resources .

5 Key points:

1. Administer IV Fluids within 1 hour of arrival
2. Administer IV antibiotics within 1 hour of arrival
3. Collect Blood cultures –
    - Two aerobic blood culture bottles are required for each episode of sepsis. Aerobic blood culture bottles are used in all patients and an additional anaerobic blood culture bottles are to be used for immunocompromised patients or in patients with suspected anaerobic sepsis e.g. intraabdominal infections, empyema.
    - Collect the blood culture specimens FIRST (inoculating the aerobic bottle first) then, if required, collect additional blood pathology tubes at this point
4. Collect serum lactate > 2mmol/L (late warning sign and indicates severe sepsis).
5. REFER and ESCALATE to senior clinicians and specialty teams, including retrieval as required

EMERGENCY TROLLEY OR RESUS TROLLEY

Resources used in the emergency response such as equipment and pharmaceuticals must be monitored and maintained daily by nursing staff e.g. emergency trolley contents, medication box intact.

Daily documentation by the ward nursing staff that the equipment has been checked is required and is to be kept for quality assurance and records retained according to General Disposal Authority requirements. **Locked** Broselow trolleys are excluded from daily checks but do require weekly, documented monitoring as per local facility by the ward nursing staff.

The minimum requirement for emergency trolleys for NON Broselow trolleys – see Appendix 3, for Broselow trolleys – see Appendix 4.

RECOGNISE, ENGAGE, ACT, CALL, HELP (REACH)

REACH is a patient and family activated escalation process. HNELHD PCP BTF - REACH Program: Patient and Family Activated Escalation PD2020_018:PCP 8

REACH empowers patients and/or their families to escalate care if they are concerned about the condition of the patient by first encouraging engagement with the treating clinicians at the bedside.
Staff are to enable patients, family and carers to utilise the REACH program by ensuring REACH posters are displayed at the patient's bedside and by providing an explanation of the system on admission.

Take the opportunity during the patient admission process, patient rounding, bedside clinical handover, or time at the patient's care board to discuss the REACH program with the patient, family or carer. It is important for them to know they can engage with staff and call for help if they are concerned.

EVALUATION AND MONITORING

- Upload data on all paediatric rapid response calls to SMaRTA Viewer monthly.
- Paediatric department/unit/ward will monitor and evaluate when issues are identified with a clinical review or rapid response call by recording the incident in IMS+.
- Auditing of the Between the Flags program in QARS using the Vital Signs for last 24hrs will be undertaken by the NUMs or a delegate in each department/unit/ward. Results are to be added to SMaRTA Viewer. Managers are to complete standard observation chart audits in May each year with additional audits to be completed monthly if results are under 80%.
- Audits will also be attended to review the escalation and outcomes of rapid response calls, arrest calls and resuscitation trolley compliance using QARS audits.
- Staff will be responsible for ensuring that they have completed the required mandatory training on My Health Learning, and keep certificates of completion as part of their professional documentation.

INCIDENT MANAGEMENT

Reports should be collated using the Patient Safety Officer (PSO) report, and any identified concerns from the clinical review or rapid response evaluation should be escalated through the Clinical Quality and Patient Care Committee (CQ&PCC).

Any unplanned event resulting in, or with the potential for, injury, damage or other loss to patients/staff/visitors as a result of this procedure must be reported through IMS+ and managed in accordance with the Ministry of Health Policy Directive PD2020-020 Incident Management. This would include unintended injury that results in disability, death or prolonged hospital stay.

EDUCATION/TRAINING REQUIREMENT

Staff working in CYPFS will have their education/training in My Health Learning

All staff working with paediatric patients MUST complete:
Medical/Nursing:
DETECT Junior or DETECT Mixed – online – Once only
DETECT Junior or DETECT Mixed face to face – Once only
RESUS4KIDS - Paediatric Life Support for Healthcare Rescuers Short Practical Course face to face – Annual
RESUS4KIDS - Paediatric Life Support for Healthcare Rescuers e-Learning online – Every four years
Allied Health:
DETECT Junior Allied Health – online – Once only
DETECT Junior Allied Health face to face – Once only
RESUS4KIDS - Basic Life Support for Allied Healthcare Rescuers Practical Course face to face – Annual
RESUS4KIDS - Basic Life Support for Allied and Community Healthcare Rescuers e-Learning online – Every four years

ROLES AND RESPONSIBILITES

AMO/VMO/ VMO GP are to:

- Provide leadership to the clinical team responsible for the patient's care, to ensure they respond as per the local CERS
- Support processes for, and awareness of, patient, carer and family escalation
- Ensure every patient, taking their diagnosis and proposed treatment into account, has an individualised assessment and monitoring plan specifying the vital sign observations and other relevant observations to be recorded and the frequency of these
- Share decision making and partner with patients, families and carers in the development and review of documented individualised assessment and monitoring plans, medical management plans and resuscitation plans, to ensure they align with the patient's goals of care
- Ensure any alterations to calling criteria are reviewed for appropriateness, formally authorised, and documented in the patient's health record
- Ensure that a medical management plan (including the monitoring plan) is reviewed and documented for all patients following a CERS call (clinical review or rapid response)

Members of the clinical team responsible for the patient's care are to:

- Discuss with the patients, carers and families about the processes available to escalate their concerns about deterioration
- Partner with patients, carers and families in the establishment of baseline observation parameters for patients to inform individualised assessment and monitoring plans and potential alterations to calling criteria
- Share decision making with patients, carers and families in the establishment of their communication preferences and needs
- Consult with the AMO/delegated clinician responsible to document a clear individualised assessment and monitoring plan that specifies the vital signs and other relevant observations to be recorded and the frequency of the observations
- Identify patients at increased risk of deterioration and deploys strategies to mitigate the risks
- Discuss with, and seek authorisation from, the AMO/delegated clinician responsible for any alterations to calling criteria and document the rationale for these alterations in the patient's health care record
- Review and confirm the provisional diagnosis and/or proposed differential diagnosis and medical management plan, including an individualised assessment and monitoring plan, for all patients following a clinical review or other CERS call, and communicate critical information about a patient's care to the AMO/delegated clinician responsible and other clinicians, as appropriate
- Communicate critical information, outcomes, alerts and risks to patients, carers and families following a clinical review and/or rapid response in a timely manner
- Escalate care as per the local CERS.

Nurse Unit Managers/ Nurse In-Charge are to:

Support processes for, and awareness of patient, family and carer escalation

- Provide leadership in monitoring compliance with the minimum requirements of the Deteriorating Patient Safety Net System, such as completion of vital sign observations at the required frequency
- Determine the need for a clinical review for patients whose vital sign observations are in the yellow zone, when additional yellow zone criteria is present or when clinicians, patients, carers or family are concerned about a patient's deterioration, and call for a clinical review or other CERS call as required
- Seek care escalation as per the local CERS in the event that a clinical review is not attended by the clinical team responsible for the patient's care, or designated responder, within 30 minutes
- Partner and communicate with the RRT during a rapid response call
- Support staff to complete relevant deteriorating patient education programs, including the allocation of protected time to attend required training
- Identify opportunities to reinforce structured communication techniques and systematic patient assessment as covered in the BTF education program during routine clinical practice

Nursing/allied health staff (within the related scope of practice) are to:

- Know how to activate, the local CERS
- Inform patients, carers and families about how to escalate their concerns about deterioration
- Conduct a systematic patient assessment, including documenting a full set of vital signs observations on an approved standard observation chart, at the frequency specified in their

individual monitoring plan. In the absence of an individual monitoring plan, refer to the appropriate approved local clinical management guideline/pathway, or the minimum requirements

- Follow the relevant coloured zone response instructions on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Increase the frequency of observations and initiate appropriate clinical care when a patient's systematic assessment triggers a blue zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Notify the Nursing Unit Manager or delegated nurse/in-charge when a patient's systematic assessment triggers a yellow zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway.
- Initiate a rapid response call and notify the Nursing Unit Manager or delegated nurse/midwife-in-charge when a patient's systematic assessment triggers a red zone response on the standard observation chart, standard clinical tool or approved local clinical management guideline/pathway, or serious concern exists about a patient's deterioration
- Document actions taken in relation to recognition, and management of deterioration in the patient's health care record
- Partner and communicate with, the RRT during a rapid response call
- Communicate critical information to the Nursing Unit Manager or delegated nurse-in-charge, and the clinical team responsible for the patient's care, if/when they are not involved in the process.

IMPLEMENTATION

The implementation of this guideline will be communicated to all staff using the CE News, education boards, educator network and clinical network streams.

Guideline and procedures will all be available through HNELHD PPG directory and HNEkidshealth website.

All new staff will be educated on the local CERS during orientation.

CONSULTATION

- Clinical Nurse Specialist/s, Paediatric wards
- Junior Paediatric Medical Officers
- Senior Paediatric Medical Officers
- Nurse Educators
    - Armidale
    - John Hunter Children's Hospital
    - Maitland
    - Manning
    - Tamworth
- Clinical Nurse Educators
- Nurse Managers
    - John Hunter Children's Hospital
- Nurse Unit Managers
    - Armidale

  - John Hunter Children's Hospital
  - Maitland
  - Manning
  - Tamworth
- Paediatricians
  - Armidale
  - John Hunter Children's Hospital
  - Maitland
  - Manning
  - Tamworth
- Quality Managers
- Children's Healthcare Network Northern - Clinical Nurse Consultants
- Acting Intensive Care and Retrieval Clinical Stream Coordinator
- JHH PICU Guideline group
- Clinical Governance - Manager, Health Systems Improvement, Improvement Program Facilitator
- HNE RAD Committee

APPENDICES

1. Fact Sheet on the Clinical Review Sticker
2. Glossary
3. Non broselow checklist minimum equipment requirements for paediatric resuscitation trolleys
4. Broselow checklist minimum equipment requirements for paediatric resuscitation trolleys

APPROVAL

CYPFS Clinical Quality & Patient Care Committee -
HNELHD Recognising and Responding to Acute Deterioration Committee

OTHER REFERENCES

NSW Health Recognition and Management of Patients who are Deteriorating PD2020_018
HNELHD Recognition and Management of Patients who are Clinically Deteriorating PD2020_018: PCP_1
PD2010_031 – Children and Adolescents Inter-facility Transfers
GL2017_010 NSW Paediatric Service Capability Framework
Clinical Excellence Commission – Between the Flags Project: The Way Forward
Clinical Excellence Commission – R.E.A.C.H Toolkit
PD2012_069 Health Care Records – Documentation and Management
GL2017_010 NSW Paediatric Service Capability Framework
PD2010_034 Children and Adolescents: Guidelines for Care in Acute Care Settings
PD2010_032 Children and Adolescents – Admission to Services Designated Level 1-3 Paediatric Medicine and Surgery
PD2010_031 Children and Adolescents – Inter-Facility Transfers
GL2014_007 NSW Rural Paediatric Emergency Clinical Guidelines Second Edition
PD2010_030 Critical Care Tertiary Networks (Paediatrics)
PD2011_038 Children and Infants – Recognition of a Sick Baby or Child in the Emergency Department
GL2018_020 Adult and Paediatric Hospital in the Home Guideline
NSW Health Policy Directive 2017_032 Clinical Procedure Safety
HNELHD PD2013_049:PCP 6 Use of the Paediatric Emergency Department Observation Charts
HNELHD PD2013_049:PCP 8: BTF - REACH Program: Patient and Family Activated Escalation

HNELHD PD2013_049:PCP 9 Altering Calling Criteria on Standard Observation Charts

HNELHD PD2013_049:PCP 10: BTF - Mandatory DETECT Education

Sepsis Pathway – Paediatric

Rural Paediatric Emergency Clinical Guidelines, Third Edition

ACSQHC National Standards (second edition): Standard 8, Recognising and Responding to Acute Deterioration

ACSQHC National Standards (second edition): Standard 1, Clinical Governance

Local CERS

GNS - JHH & JHCH - Urgent Clinical Review and Escalation (CERS)

LHS - Clinical Emergency Response System (CERS) TMH Paediatric and Neonatal

LMNCS - Bulahdelah - Paediatric CERS

LMNCS - Manning - Paediatric CERS

TS - Armidale Rural Referral Hospital Clinical Emergency Response System (CERS)

PS - Tamworth RRH - Clinical Emergency response System (CERS) Tamworth Hospital

FEEDBACK

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

APPENDIX 1: FACT SHEET ON THE CLINICAL REVIEW STICKER

FACT SHEET

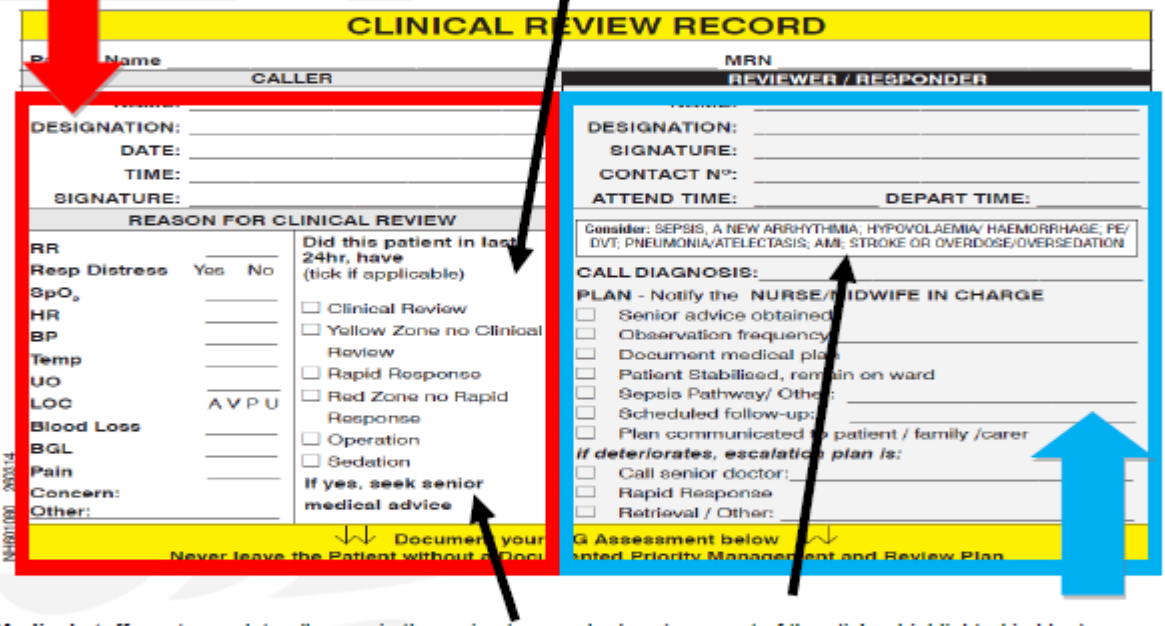
Issued: 13th April 2016

CLINICAL REVIEW RECORD STICKER

When an urgent clinical review has been requested, the below sticker must be placed in the patient's health care record for completion by medical and nursing/midwifery staff. Additionally, the caller and reviewer/responder must document the patient's A-G assessment, treatment and outcome.

NURSING/MIDWIFERY STAFF must complete the information in the caller box (highlighted in red), including documenting patient's name and MRN, and reason for call. When calling for an urgent clinical review, please state the reason of concern.

Also indicate if the patient had one of the listed events in the last 24 hours. If yes, seek senior medical advice.



Medical staff must complete all areas in the review/responder box (grey part of the sticker highlighted in blue). Note: check whether the patient had one of the listed events in the last 24hrs and, if so, seek senior medical advice.

AT THE END OF THE CLINICAL REVIEW, A PRIORITY MANAGEMENT AND REVIEW PLAN MUST BE DOCUMENTED IN THE PATIENT'S NOTES AND COMMUNICATED TO THE NURSING/MIDWIFERY STAFF RESPONSIBLE FOR THE CARE OF THE PATIENT.

AT ALL TIMES IF YOU ARE CONCERNED ABOUT A PATIENT OR A PATIENT DETERIORATES, FOLLOW THE LOCAL PROCEDURE FOR ESCALATION (JHH_JHCH_0019)

All units are expected to commence using this sticker by 1 July 2016 to allow time for education. Any concerns, please contact Marie O'Donnell, Service Manager, Medical & Interventional Services and Chair of John Hunter Resuscitation and Deteriorating Patient Committee.

NB. The Clinical Review Sticker can be ordered through Stream Solutions – 'Find Product by Search' (Product Code NH601080)

Local Procedure: Urgent Clinical Review and Escalation
Document Number: JHH_JHCH_0019

NSW GOVERNMENT Health
Hunter New England
Local Health District

APPENDIX 2: GLOSSARY

Acronym or Term	Definition

AMO	Admitting Medical Officer
AVPU	Alert, Voice, Pain, Unresponsive
BGL	Blood Glucose Level
B.P	Blood Pressure
CERS	Clinical Escalation Response System
GCS	Glasgow Coma Score
HR	Heart rate
HT	Height
JHCH	John Hunter Children's Hospital
LOC	Level of Consciousness
P	Pulse
PARU	Post Anaesthetic Recovery Unit
PEDOC	Paediatric Emergency Department Observation Chart
RD	Respiratory Distress
REACH	Recognise, Engage, Act, Call and Help, Patient/Carer activated escalation system
Resp	Respiratory
RMO	Resident Medical Officer
RR	Respiratory rate
RRT	Rapid Response Team
SMaRTA Viewer	Strategic Management and Reporting Tool for Accountability Viewer
SpO_2	Peripheral capillary oxygen saturation
SPOC	Standard Paediatric Observation Chart
QARS	Quality Audit Reporting System
T	Temperature
UA	Urinalysis
VBG	Venous Blood Gas
WT	Weight

APPENDIX 3: NON BROSELOW CHECKLIST MINIMUM EQUIPMENT REQUIREMENTS FOR PAEDIATRIC RESUSCITATION TROLLEYS

Recommended NON Broselow ™ Trolley Checklist for Paediatric Resuscitation Trolleys

DATE:								
Side of trolley					.			
Self-inflating BVM : "child" with size 1-2 clear face mask								
Self-inflating BVM : "adult" with size 4-5 clear face mask								
Portable oxygen cylinder with flow meter and tap attached to side								
Suction available with tubing and paediatric yankeur sucker								
Sharps bin								
Paediatric stethoscope								
Broselow™ Paediatric Emergency Tape								
On top of trolley								
Paediatric advanced life support resuscitation charts/algorithms								
Defibrillator or known location of Defibrillator								
Top drawer								
Drug dosage handbooks e.g. Frank Shann Drug Doses (2017) Monash-Paediatric Emergency Medication book								
Pharmacy pack – see facility recommended resuscitation medication/fluid list.								
Drug labels								
Calculator								
Adhesive tape - ½ inch and 1 inch brown leukoplast tape								

1

- *Site dependant* or optional if immediately available in department
- **Trolley checking to be done daily.**

Children's Healthcare Networks/Northern 2020

Recommended NON Broselow ™ Trolley Checklist for Paediatric Resuscitation Trolleys

Trache tape – 1 metre length								
Hydrocolloid dressing - 1 sheet								
Pen torch								
Tongue depressor x 1								
Scissors								
Airway equipment								
ETT uncuffed x 1 each sizes 2.5, 3.0, 3.5, 4.0, 4.5								
Paediatric cuffed ETT 3.0, 3.5. 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0								
Suction catheters - 6 FG x1, 8 FG x1, 10FGx1, 12FGx1								
Clear face masks 00, 0, 1, 2, 3, 4								
Oropharyngeal airway 00 & 0 (40mm - 60mm), 1 (70mm), 2 (80-90mm) & 3 (100-110)								
Tongue depressor								
LMA Supreme/i-gel® size 1, 1.5, 2, 2.5, & 3								
Suction Catheter size 6FG x 1, 8FG x1, 10FGx1, 12FGx1								
Laryngoscope handle								
Laryngoscope blades straight size 0,1,2,3 curved sizes 1,2,3								
Manometer required for all cuffed ETTs								
Magill's forceps – neonatal and paediatric								
ETT introducers size small & medium								
Lubricating jelly								
Paediatric colorimetric CO_2 detector 1kg-15kg, Adult colorimetric CO_2 detector >15kg								

- *Site dependant* or optional if immediately available in department
- **Trolley checking to be done daily.**

Recommended NON Broselow ™ Trolley Checklist for Paediatric Resuscitation Trolleys

IV cannulation equipment								
22G, 24G, 20G, 18G & 16G cannula x 1 each								
Extension tube x 3								
Paediatric tegaderm								
Alcohol wipes x 2								
3 way tap x 2								
Syringes 3mL, 5mL, 10mL x 1 each								
0.9% Sodium Chloride 10mL x 3								
Neonatal arm board x 1, Infant arm board x1 & Paediatric arm board								
Intraosseous equipment								
Alcohol swabs x 6								
Intraosseous needle or EZ IO drill with various sized needles pink x 2, blue x 2 and yellow (optional) x 2								
3 way tap x 2								
Syringes 50mL (luer lock) x 1								
Syringe 20mL (luer lock) x1								
Umbilical Catheter Placement kit								
Umbilical catheter single lumen 3.5 FG								
Oro/nasogastric tube insertion equipment								
8FG, 10G, 12G & 14G gastric tube x 1 each								
20mL syringe								
Free drainage bag/ container								
pH indicator strips (0.5 increments)								

- *Site dependant* or optional if immediately available in department
- **Trolley checking to be done daily.**

Recommended NON Broselow ™ Trolley Checklist for Paediatric Resuscitation Trolleys

Bottom Drawer								
Needle thoracocentesis pack: 14G, 16G cannula, 3 way tap, 20mL syringe, Op site x 2 alcohol wipes								
ECG dots								
5% Glucose 250mL x1								
10% Glucose 1L x 1								
0.9% Sodium Chloride 1L x 1								
Burette/pump giving set x 1								
Transfusion pump set x 1								
Syringes – leur lock 50mL x 2								
3 way tap x 2								
Drawing up needles (blunt 18g) x 20								
Batteries for laryngoscopes. Spare AA and C batteries								
Oxygen saturation probess - infant and child								
Tourniquet								
Defibrillation pads - paediatric size and adult size x 1 each								
Initials								
Actions								

- *Site dependant* or optional if immediately available in department
- **Trolley checking to be done daily.**

Recommended NON Broselow ™ Trolley Checklist for Paediatric Resuscitation Trolleys

Bottom Drawer								
Needle thoracocentesis pack: 14G, 16G cannula, 3 way tap, 20mL syringe, Op site x 2 alcohol wipes								
ECG dots								
5% Glucose 250mL x1								
10% Glucose 1L x 1								
0.9% Sodium Chloride 1L x 1								
Burette/pump giving set x 1								
Transfusion pump set x 1								
Syringes – leur lock 50mL x 2								
3 way tap x 2								
Drawing up needles (blunt 18g) x 20								
Batteries for laryngoscopes. Spare AA and C batteries								
Oxygen saturation probess - infant and child								
Tourniquet								
Defibrillation pads - paediatric size and adult size x 1 each								
Initials								
Actions								

- *Site dependant* or optional if immediately available in department
- **Trolley checking to be done daily.**

APPENDIX 4: BROSELOW CHECKLIST MINIMUM EQUIPMENT REQUIREMENTS FOR PAEDIATRIC RESUSCITATION TROLLEYS

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

DATE:								
Side of Trolley					.			
Self-inflating BVM : "child" with size 2 clear face mask								
Self-inflating BVM : "adult" with size 4-5 clear face mask								
Portable oxygen cylinder with flow meter and tap attached to side								
Suction available with tubing and paediatric yankeur sucker								
Sharps Bin								
Paediatric stethoscope								
Broselow™ Paediatric Emergency Tape								
On top of trolley								
Paediatric Advanced life support resuscitation charts/algorithms								
Defibrillator or known location of Defibrillator								
Top Grey Drawer 1								
Drug dosage handbooks e.g. Frank Shann Drug Doses (2017) Monash-Paediatric Emergency Medication book								
Pharmacy pack – see facility recommended resuscitation medication/fluid list.								
Drug labels								

1

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

Children's Healthcare Networks/Northern 2020

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

Calculator								
Laryngoscope handle								
Laryngoscope blades straight size 0,1,2,3 curved sizes 1,2,3								
Manometer required for all cuffed ETTs								
Magill's forceps – neonatal and paediatric								
ETT Introducers size small & medium								
Lubricating jelly								
Adhesive tape - ½ inch and 1 inch brown leukoplast tape								
Trache tape – 1 metre length								
Paediatric Colorimetric CO_2 detector 1kg-15kg, Adult Colorimetric CO_2 detector >15kg								
Hydrocolloid Dressing - 1 sheet								
Pen torch								
Tongue Depressor x 1								
Scissors								
pH indicator strips (0.5 increments)								
Bottom Drawer								
<u>Needle Thoracocentesis Pack:</u> 14, 16 Gauge Cannulae, 3 way tap, 20mL syringe, Op site x 2, Alco wipes								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

ECG dots								
5% Glucose 250mL x1								
10% Glucose 1L x 1								
0.9% Sodium Chloride 1L x 1								
Burette/pump giving set x 1								
Transfusion pump set x 1								
Syringes – Leur lock 50mL x 2								
3 way tap x 2								
Drawing up Needles (blunt 18g) x 20								
Batteries for laryngoscopes. Spare AA and C batteries								
Oxygen saturation probes - infant and child								
Tourniquet								
Defibrillation pads - paediatric size and adult size x 1 each								
Intraosseous pack (sealed)								
Alcohol swabs x 6								
Intraosseous needle or EZ IO drill with various sized needles pink x 2, blue x 2 and yellow (optional) x 2								
3 way tap x 2								
Syringes 50mL (Luer lock) x 1								
Syringe 20mL (Luer lock) x1								
Syringes 5mL (Luer lock) x1								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

Drawer 2 Pink/Red Infant < 10kg								
Endotracheal tube pack (sealed)								
ETT uncuffed x 1 each sizes 2.5, 3.0, 3.5, 4.0								
Paediatric Cuffed ETT 3.0, 3.5								
Suction catheters - 6 FG x1, 8 FG x1								
Loose in pink/red drawer								
Clear face masks 00, 0, 1								
Oropharyngeal airway 00 & 0 (40mm - 60mm)								
Tongue depressor								
LMA Supreme/i-gel® size 1 & 1.5								
Suction Catheter size 6FG x 1, 8FG x1								
Umbilical Catheter Placement kit								
Umbilical catheter single lumen 3.5 FG								
IV cannulation pack (sealed)								
22G, 24G cannulae x 1 each								
Extension tube x 1								
Paediatric Tegaderm								
Alcohol wipes x 2								
3 way tap x 2								
Syringes 3mL, 5mL x 1each								
0.9% Sodium Chloride 10mL x 1								
Neonatal arm board x 1, Infant arm board x1								

- *Site dependant* or optional if immediately available in department
- Please seal packs –1st due expiry date to be written on outside of sealed pack.
- If trolley sealed checking to be done weekly.

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

Oro/Nasogastric insertion pack (sealed)								
8FG gastric tube								
20mL syringe								
Free drainage bag/ container								
Drawer 3 Purple Small child 10-11kg Endotracheal tube pack (sealed)								
ETT uncuffed tubes sizes 4.0 x 1								
Paediatric Cuffed ETT 3.5								
Suction catheter 6FG x1, 8FG x 1								
Loose in purple drawer								
Clear face mask 2								
Oropharyngeal airway 1 (70mm)								
Tongue depressor								
LMA Supreme/i-gel® size 2								
Suction Catheter size 6FG x 1, 8FG x 1								
IV cannulation pack (sealed)								
22G, 24G cannulae x 1 each								
Extension tube x 2								
Paediatric Tegaderm								
Syringes 3mL, 5mL & 10mL x 1 each								
0.9% Sodium Chloride amp 10mL x 1								
3 way tap x 1								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

Infant arm board x 1								
Oro/Nasogastric insertion pack (sealed)								
8FG gastric tube								
20 mL syringe								
Free drainage bag/ container								
Drawer 4 Yellow 12-15kg								
Endotracheal tube pack (sealed)								
ETT uncuffed sizes 4.5 x 1								
Paediatric Cuffed ETT 4.0								
Suction catheter 8FG x 1								
Loose in Drawer								
Clear Face mask 2								
Oropharyngeal airway size 1 (70mm)								
Tongue depressor								
LMA Supreme/i-gel® size 2								
Suction Catheter size 8FG x 1								
IV Cannulation pack (sealed)								
24G, 22G, 20G Cannula x 1each								
Extension tube x 1								
Paediatric Tegaderm								
Syringes 3mL, 5mL, 10mL x 1 each								
0.9% Sodium Chloride 10mL amp x 1								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

3 way tap x 1								
Infant arm board x1, Paediatric arm board x 1								
Oro/Nasogastric insertion pack (sealed)								
10FG gastric tube								
50mL catheter tip syringe								
Free drainage bag/ container								
Drawer 5 White 16-18kg								
Endotracheal tube pack (sealed)								
Paediatric ETT cuffed tubes sizes 4.5								
Suction catheter 8FG x 1								
Loose in drawer								
Oropharyngeal airway sizes 1 (70mm)								
Clear face masks 2, 3								
Tongue depressor								
LMA Supreme/i-gel® size 2								
Suction Catheter size 8FG x 1, 10FG x 1								
IV Cannulation pack (sealed)								
22G, 20G, 18G cannula x 1								
Extension tube x 1								
Paediatric Tegaderm								
Syringes 3mL, 5mL, 10mL x 1 each								
0.9% Sodium Chloride 10mL amp x 1								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

3 way tap x 1								
Paediatric arm board x 1								
Oro/Nasogastric insertion pack (sealed)								
10 FG gastric tube								
50mL catheter tip syringe								
Free drainage bag/ container								
Drawer 6 Blue 19-23kg								
Endotracheal tube pack (sealed)								
Paediatric ETT cuffed tubes size 5.0, 5.5								
Suction catheter 10FG x 1								
Syringe 10mL x 1								
Loose in drawer								
Clear face masks sizes 2 and 3								
Oropharyngeal airway size 2 (80-90mm)								
Tongue depressor								
LMA Supreme/i-gel® size 2.5								
Suction Catheter size 8FG x 1, 10FG x 1								
IV cannulation pack (sealed)								
22G, 20G, 18G cannula x 1 each								
Paediatric Tegaderm								
Syringes 3mL , 5mL, 10mL x 1 each								
0.9% Sodium Chloride 10mL amp x 1								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

3 way tap x 1								
Extension tube x 1								
Paediatric arm board x 1								
Oro/Nasogastric insertion pack (sealed)								
10 FG gastric tube								
50mL catheter tip syringe								
Free drainage bag/ container								
Drawer 7 Orange small adult 24-28kg								
Endotracheal tube pack (sealed)								
Paediatric ETT cuffed tube size 5.5, 6.0								
Suction catheter 10FG								
Syringe 10mL x 1								
Loose in drawer								
Clear face mask size 3								
Oropharyngeal airway size 3 (80-90mm)								
Tongue depressor								
LMA Supreme size/i-gel® 2.5								
Suction Catheter size 10FG x 1, 12FG x1								
IV Cannulation pack (sealed)								
22G, 20G, 18G cannula x 1 each								
Extension tube x 1								
Paediatric Tegaderm								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

Syringes 3mL, 5mL, 10mL x 1 each								
0.9% Sodium Chloride 10mL amp x 1								
3 way tap x 1								
Paediatric arm board x 1								
Oro/Nasogastric insertion pack (sealed)								
12, 14FG gastric tube								
Syringe 50mL catheter tip								
Free drainage bag/ container								
Drawer 8 Green 30-40kg small adult								
ETT cuffed tube size 6.5, 7.0								
Suction catheter 12G x 1								
Syringe 10mL x 1								
Loose in drawer								
Clear face mask size 4								
Oropharyngeal Airway sizes 3 (80-90mm)								
Tongue depressor								
LMA Supreme /i-gel®size 3								
Suction Catheter size 12FG x1								
IV cannulation pack (sealed)								
20G, 18G, 16G cannula x 1each								
Extension tube x 1								
Paediatric Tegaderm								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

Syringes 3mL, 5mL, 10mL x 1 each								
0.9% Sodium Chloride 10mL amp x 1								
3 way tap x 1								
Paediatric arm board x1, adult arm board x 1								
Oro/Nasogastric insertion pack (sealed)								
12, 14FG gastric tube								
Syringe 50 mL catheter tip								
Free drainage bag/ container								
Initials								
Actions								

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**

NSW CHILDREN'S HEALTHCARE NETWORK

Recommended Paediatric Broselow ™ Trolley Checklist

ALERT:

Remember Infection Prevention Control principles and consider the need for contact, droplet and/or airborne precautions in each individual case.

If using Paediatric Cuffed ETT use a 3mL syringe to inflate the cuff to the safe range 5-15cmH_2O with minimal air leak.

Do not use the bulb of the manometer to inflate the cuff. This can cause the cuff to over-inflate.

References:

NETS (2011) Management of Cuffed Endotracheal/Tracheostomy Tubes
http://www.nets.org.au/img.ashx?f=f&p=clinical_guidelines%2fManagement+of+cuffed+ETT+-+last+updated++Dec+2011.pdf >accessed 18/03/14<

Kimberly Clarke Microcuff Paediatric Endotracheal Tube.

Fine G, Maxwell, L and Gerber, A. (2008) New Advances in Paediatric Ventilation: Revolutionizing the Management of Pediatric Intubation with Cuffed Tubes.

Infants and Children Insertion and Confirmation of Placement of Nasogastric and Orogastric Tubes. GL2016_006
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2016_006.pdf

Note:
LMA sizes are based on the Supreme™ brand from Teleflex Medical, and the i-gel® brand from © Intersurgical Australia Pty Ltd
Cuffed ETT sizes are based on Halyard Microcuff Paediatric Endotracheal Tube Sizing Chart,
Umbilical catheter placement kit and umbilical catheter as recommended by NETS- (Vygon brand)

Drug books:

Drug Doses Frank Shann 2017 orders@drugdoses.com

Paediatric Emergency Medication book

- *Site dependant* or optional if immediately available in department
- **Please seal packs –1st due expiry date to be written on outside of sealed pack.**
- **If trolley sealed checking to be done weekly.**