Guideline

Admission Documentation and Requirements for Paediatric Inpatients

Sites where Guideline and Procedure applies	All sites where paediatric patients are admitted as inpatients, excluding NICU
This Guideline and Procedure applies to:	
1. Adults	No
2. Children up to 16 years	Yes
3. Neonates – less than 29 days	Yes
Target audience	Medical and nursing staff
Description	Requirements to conduct a comprehensive assessment on all admitted patients.

Go to Guideline

Keywords	Paediatric, admission, falls, pressure injury, glamorgan, emergency equipment, documentation, REACH, child safety and welfare, Paediatric Patient Safety Briefing
Document registration number	HNELHD Guideline 20_09
Replaces existing document?	No

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

NSW Health GL2018_003 Youth Health and Wellbeing Assessment
NSW Health PD2012_069 Healthcare Records - Documentation and Management
HNELHD PD2012_069:PCP 6 Minimum Standard for Medical Documentation
HNELHD Pol 18_06:PCP 4 Hourly Rounding and Documentation of Care
HNELHD PD2011_015:PCP 1 Safety Huddles

Guideline and Procedure note	This document reflects what is currently regarded as safe and appropriate practice. The guideline section does not replace the need for the application of clinical judgment in respect to each individual patient but the procedure/s **require mandatory compliance**. If staff believe that the procedure/s should not apply in a particular clinical situation they must seek advice from their unit manager/delegate and document the variance in the patient's health record.
Position responsible for the Guideline and Procedure and authorised by	Paul Craven, Executive Director, Children, Young People and Families Services
Contact person	Camilla Askie
Contact details	Camilla.Askie@health.nsw.gov.au
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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.

We would like to acknowledge the content of this document was taken from other children's hospital admission guidelines including Sydney Children's Hospitals Network and The Royal Children's Hospital Melbourne.

Table of Contents

Purpose and Risks......3
Staff Preparation......3
Admission Requirements......3
Height and Weight......4
Paediatric Nutrition Screening Tool (PNST)......5
Patient Identification......5
Allergies......5
Child Safety and Welfare (parents/carers are NOT to be asked these questions)......5
Falls......6
Pressure Injuries......6
Skin Inspection......6
The Young Person's Safety Briefing......6
Youth Health and Wellbeing Assessments (Patients over 12yrs of age)......6
Nursing Care Plans......7
Ward Orientation......7
Interpreter Service......8
REACH......9
Discharge Planning......9
Communication......9
Emergency Equipment Check......9
Documentation......10
Short Stay Patients......11
Implementation, Monitoring Compliance and Audit......11
References......11
Appendix 1: Paediatric Risk Assessment Tool (PRAT)......13
Appendix 2: Paediatric Nursing Assessment and Care Plan......15
Appendix 3: Youth Health and Wellbeing Assessments......17
Appendix 4: Body Mass Index (BMI) for age percentile charts......19
Appendix 5: Pressure Injury Classification System......20
Glossary......21

Purpose and Risks

The purpose of this document is to provide all patient with consistent and timely nursing assessment across Hunter New England Local Health District (HNELHD). It is a requirement from the National Safety and Quality Health Service Standard (NSQHSS) and the Nursing and Midwifery Board of Australia (NMBA) to conduct a comprehensive assessment on all admitted patients. By completing the assessment any potential risks can be identified and managed with the patient/parent/carer and staff. Any incidents that arise from not conducting the assessment or found during the assessment need to be entered into Incident Information Management System -IMS+.
Risk Category: Clinical Care and Patient Safety

Staff Preparation

It is mandatory for staff to follow relevant five moments of hand hygiene, infection control, moving safely/safe manual handling, documentation practices and to use HAIDET for patient/carer communication (Hand hygiene Acknowledge, Introduce, Duration, Explanation, Thank you or closing comment).

GUIDELINE

This Guideline does not replace the need for the application of clinical judgment in respect to each individual patient.

Assessment is a key component of nursing practice, required for planning and provision of patient and family centered care. The NMBA national competency standard for registered nurses states that nurses:

> *"Conducts a comprehensive and systematic nursing assessment, plans nursing care in consultation with individuals/groups, significant others and the interdisciplinary healthcare team and responds effectively to unexpected or rapidly changing situations".*

Admission Requirements

The nurse admitting the patient to the ward/unit is responsible for the completion of the admission. A Paediatric Nursing Assessment and Care Plan and Paediatric Risk Assessment Tool must be completed on the patient's arrival to the ward/unit.

- There is an expectation, a complete paediatric admission is to be carried out when the patient arrives to the ward/unit.

Nursing staff should discuss and record the history of current illness/injury (i.e. reason for current admission), relevant past history, allergies and reactions, medications, immunisation status and family and social history. Recent overseas travel should be discussed and documented.

A consistent, timely and comprehensive nursing assessment includes patient history, general appearance, physical examination and vital signs.

Admitting a patient to the ward is an important step in the care of the child. This is a valuable time to gain baseline information about the patient, but also an opportunity to orientate the family to the ward and the patient's care needs.

The following forms/actions make up the paediatric admission and **MUST** also be completed when a paediatric patient arrives to an inpatient ward/unit:

1. Paediatric Risk Assessment Tool (PRAT) - All sections of the charts are mandatory (See Appendix 1).
2. Paediatric Nursing Assessment and Care Plan - All sections of the charts are mandatory (See Appendix 2).
3. Youth Health and Wellbeing Assessments (Patients over 12yrs of age) (See Appendix 3)

4. Full set of core observations. Blood pressure (BP) is required at least once during the admission (on admission then continuing if indicated by clinical condition). All observations MUST be documented on the age appropriate Standard Paediatric Observation Chart (SPOC) or Paediatric Emergency Department Observation Chart (PEDOC).
   Core observations include: temperature (T), heart rate (HR) 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), Blood pressure (BP) is required at least once during the admission (on admission then continuing if indicated by clinical condition).

- **Temperature**: Tympanic temperatures for children older than 6 months, except when otitis media is indicated. If less than 6 months use digital thermometer per axilla. Forehead digital thermometers may be used, ensure correct calibration prior to use as per manufactures instructions.
- **Respiratory Rate**: Count the child's breaths for 1 full minute.
- **Respiratory distress:** Assessment of respiratory distress is on the SPOC, outlining criteria for mild, moderate and severe respiratory distress. Watch for tracheal tug, intercostal recession, sternal recession, head bobbing, flared nostrils, and grunting.
- **Heart Rate**: Palpate brachial pulse (preferred in neonates) or femoral pulse in infant and radial pulse in older children. To ensure accuracy, count pulse for a full minute.
- **Blood Pressure**: Baseline measurement should be obtained for every patient. Selection of the cuff size is an important consideration. A rough guide to appropriate cuff size is to ensure it fits a 2/3 width of upper arm.
- **Oxygen Saturation**: Monitor as clinically indicated. Note oxygen requirement and delivery mode.
- **Pain**: Use the Face, Legs, Activity, Cry, Consolability scale (FLACC), Faces - numeric scale self-assessment or the Neonatal Pain Assessment Tool as appropriate to the age group.
- **Level of Consciousness**: (LOC) using Glasgow Coma Score (GCS) or Alert, Voice, Pain, Unresponsive (AVPU). Use GCS or AVPU.

5. Circulation: Capillary refill, skin appearance (mottled, clammy, pale)
6. Patient Identification – including the application of identification and allergy bands (if applicable) if not already insitu.
7. Height and weight plus entry into Med Chart (with the same date)
8. Plotting BMI on BMI chart and discussion about 8 Healthy Habits if patient, parent, carer agree and it is an appropriate time. Document in the patient's health care record the outcome of the discussion the patient/parent/carer.
9. **Babies under 12 months to be bare weighed**, i.e. all clothing and nappy to be removed prior to being weighed.
10. Head circumference (HC) - All patients less than 2 years of age require a HC.
11. Orientation to the ward for family.
12. Hourly Rounding Care Plan.
13. Information on - prevention of falls and pressure injuries, REACH, patient care boards and The Young Person's Safety Briefing.

Any identified risks should be communicated to staff and families. Appropriate care actions should be implemented and documented in the patient healthcare record.

Height and Weight

Healthy Weight Program

HNELHD is required to maintain a process for measuring children's growth when seen in a healthcare facility at least once every 90 days.

This is part of a wider strategy to improve children's health and reduce the rising rates of childhood obesity. Part of this Government strategy is an early intervention approach to raise awareness of the impact increased weight has on overall health and provide information on lifestyle choices that support healthy growth in Australian children. Online resources for the Premier's Priority can be found on the healthykids for professionals website.

Medical, Nursing and Allied Health staff are required to plot the patients BMI on a specific BMI percentile chart (see Appendix 4 - forms can may be ordered through Stream) for the patient's sex and age. Identify if the patient is above, below or in a healthy weight range and then briefly discuss this with the patient (where appropriate), parent or carer. If the patient's weight is in the above or below healthy weight categories, there are weight management resources to assist the family and the health professionals. There are 8 Healthy Habits on the back of the BMI form to help maintain a healthy lifestyle.

The patient's weight MUST be re-measured at day 7 of admission as well as conducting a repeat of the Paediatric Nutritional Screening Tool (PNST). The weight and the height are to be re-entered into Med Chart. You can use the same height as on admission.

Paediatric Nutrition Screening Tool (PNST)

To complete a PNST ask the patient/parent/carer the 4 questions from the PRAT and document the result in the patient's healthcare record. If they answer yes to 2 or more of the questions in the PNST then a referral to a dietitian is required.

Patient Identification

Identification of a patient promotes patient safety and prevents complications including wrong procedures, medication errors, transfusion errors and diagnostic testing errors.

As per NSW health policy directive patients are to wear one identification band, either a white / clear band or a red band at all times. The application of these specifications to identification bands should be done in a way that is relevant to the specific circumstances of the patient and the health care setting.

Identification bands are a critical tool to prevent errors associated with mismatching patients and their care. Identification bands contain important information about the patient and are essential for establishing and checking identity of the patient throughout the care process.

When applying the identification band, the three (3) core patient identifiers must be documented and verified with the patient/parent/carer:

- MRN
- Full name
- Date of birth

Allergies

If the patient has a documented drug allergy and/or adverse reaction to a medicine, the white identification band is replaced with a red identification band with a white panel and black text. The allergy is not to be recorded on the band. Staff are to refer to the patient's records for this information. Do not add any other allergies other than medicines.

Food allergies need to be entered into the food service system – CBORD.

Child Safety and Welfare (parents/carers are NOT to be asked these questions)

This is an initial snapshot in time assessment on admission. Staff need to re-assess if any concerns arise during the admission.

Observe the patient/parent/carer and family for the length of time that you have and complete the assessment based on the interactions for that time.

This assessment should be reviewed on a regular basis by all healthcare professionals and the result may change with further information and time.

Falls

Complete assessment on admission. Repeat assessment every 3 days plus if condition changes e.g. transfer wards, goes to theatre. The repeat assessment is for every patient. Record the re-assessment on the care plan and any management strategies in the healthcare record. For patients at high risk of falling, complete a care/management plan with the patient/parent/carer. Ensure the plan outlining the steps you have taken to minimise any risk/s is placed in the healthcare record.

Pressure Injuries

Complete assessment on admission. Repeat every 3 days plus if condition changes e.g. transfer wards, goes to theatre. The repeat assessment is for every patient. For patients at high risk of pressure injuries, complete a care/management plan with the patient/parent/carer. Ensure the plan outlining the steps you have taken to minimise any risk/s is placed in the healthcare record. E.g. Ordered and transferred patient onto an alternating pressure mattress. If an injury does occur, pressure injury incidents must be recorded and documented in the incident reporting system (e.g. IMS+) in accordance with the NSW Health Incident Management Policy.

When a community acquired pressure injury (PI) is found it MUST be documented in the patient's healthcare record and given a stage from 1 to 4, Stage 1 indicates non-blanching erythema up to stage 4 indicating full thickness tissue loss. Without the staging documented, all pressure injuries are given the worst rating and HNELHD are penalised for each of these. See PI Stages, Appendix 5

Skin Inspection

Visualise skin and document integrity. Complete on admission. This does not need to be a formal review. Passive observation of integrity will occur when you are attending the core observations as you will visualise the skin integrity of the patient e.g. arms when applying BP cuff or observing the chest/abdomen when assessing level of respiratory distress.

The Young Person's Safety Briefing

The Paediatric Patient Safety Briefing video. The Person's Safety Briefing video gives an overview for patients, carers and family members on key safety areas to keep patients safe during their hospital stay. It includes information on falls prevention, hand hygiene, invasive devices such as cannulas, pressure injury prevention, medication safety, patient identification and follow up phone calls.

Youth Health and Wellbeing Assessments (Patients over 12yrs of age)

(See Appendix 3)

Youth health and wellbeing assessments are important to assist clinicians to identify and respond early to areas of concern in a young person's life that might affect their health and wellbeing.

The youth health and wellbeing assessment is not a diagnostic tool. It is a holistic, flexible approach designed to build rapport and engage with a young person in a clinical setting. The information gathered can then be used to directly address any concerns and/or refer a young person for a specialist response.

The most widely used youth health and wellbeing assessment tool in Australia and internationally is known as a HEEADSSS assessment.

Each letter of HEEADSSS reflects a major domain of a young person's life. Capturing information in

each domain helps reveal risks, behaviours and protective factors. It helps to identify areas of intervention where the clinician can work with the young person to achieve better health outcomes.

- H - Home
- E - Education and Employment
- E - Eating and Exercise
- A - Activities, Hobbies and Peer Relationships
- D - Drug Use (cigarettes, alcohol)
- S - Sexual Activity and Sexuality
- S - Suicide, Self-Harm, Depression, Mood, Sleeping Patterns
- S - Safety and Spirituality

In general, a youth health and wellbeing assessment should be conducted with every young person (12-24 years old) who attends a health service or hospital. Where appropriate young people in an adult or paediatric inpatient area within a hospital should have a youth health and wellbeing assessment completed in conjunction with other screening assessment/admission processes.

Clinical judgement should be used to determine the appropriateness of the assessment for 12-24 year olds. This includes considering the young person's health condition, maturity, the environment and health service context. For example, sufficient time or privacy may not be available in an Emergency Department context.

In general, an assessment is done through conversation with a young person. On some occasions, where it is more appropriate a young person can be asked to complete the Youth Health and Wellbeing Assessment Chart.

For further information see NSW Health GL2018_003 Youth Health and Wellbeing Assessment Guideline NSW Health GL 2018_003 Youth Health and Wellbeing Assessment. There is also a My Health Learning module: 99482031 HEEADSSS - Get the Conversation Started. This module will explore ways a health worker can use the HEEADSSS framework to engage a young person in a conversation that will assist with meeting their health and well-being needs.

Nursing Care Plans

Care Plans are to be completed on admission and then revised and signed for **when care changes** i.e. NOT routinely signed at the end of each shift.

May require more than one revision in a shift (e.g. pre and post operatively). Or may require no revision of care during a shift.

Involve the patient/parent/carer in the development of the Nursing Care Plans.

Ward Orientation

Basic orientation is vital to the patient/parent/carer's hospital experience. It is sometimes difficult to find a staff member to ask simple questions i.e. where the bathroom is located. Prompts for orientation are on the Paediatric Nursing Assessment and Care Plan in the section 2 table on the form – see below snapshot.

Orientation to Ward (tick when discussed with parent / carer / child)			
Parent / Family accommodation		Patient call system	
Visiting Hours		Process for escalating care discussed with family	
Meal Times / Food Services		Medications / NO self-medicating	
Ward Routine		Rights & Responsibilities and Privacy brochures (NSW Health)	
Unit Manager / Nurse-in-charge		Family advised of EDD	
Telephone / mobiles/ TV		Belongings & Valuables	
Parking / Transport		Smoking Regulations	
Relevant fact sheet given		Interpreter services contacted (if required)	
Orientation to the ward		Aboriginal Liaison Officer contacted (if appropriate)	

Remember to use the Patient Care Boards (PCB) as they are a patient communication tool to involve the patients in their plan of care. The PCB needs to be easily accessible to the patient and updated regularly by all members of the healthcare team together with the patient/carer/family so they clearly understand and **agree with or consent to** the information displayed. The patient/carer/family should be encouraged to ask questions or make comments using the PCB.

Infection Control

Infectious patients must have appropriate sign/s applied to the door of their room indicating precautions. Alert to infectious status needs to be communicated to the ward before admission if known. Where required, the Influenza Like Illness 'ILI' sticker is to be completed and added into patient's healthcare record.

Interpreter Service

Staff should assess if the patient/parent/carer requires the interpreter service. The service provides interpreting services 24 hours a day, 7 days a week.

How to book an interpreter

For the Hunter region during business hours (8.30am to 5pm), please phone 02 4924 6285.

For the Hunter region after hours, please phone 02 4921 3000.

For other rural areas within the Hunter New England region, please phone 1800 674 994.

Information needed for interpreter bookings

All interpreter bookings go through the central booking system through the contact numbers provided above. The following information should be provided at the time of booking:

1. Language needed
2. Time and date of appointment
3. Estimated duration of appointment
4. Location/hospital/service
5. Contact name and phone number
6. Health professional's name
7. Client name and MRN (for HNELHD only)
8. Medical condition
9. Any special circumstances or needs

Medications

Staff are to inform parents/carers not to administer their own medications to the child. All administration of medications whilst in hospital should be checked and signed by nursing and/or

medical staff.

If the parents/carers have brought their child's medications to hospital, staff are encouraged to inform the parents/carers to take them home. If the family is unable to take the medications home, they should be removed from the bedside, labelled and placed in the locked medication room ready to be returned to the patient and family on discharge.

REACH

The letters REACH stand for Recognise, Engage, Act, Call and Help is on its way.

Staff are to inform the patient/parent/carer of the REACH program and its purpose. They should be informed of how to escalate concerns prior to a REACH call being made and how to make a REACH call. Refer to poster at each bedside.

REACH is a patient and family activated escalation process developed by the Clinical Excellence Commission's (CEC) Directorate of Patient Based Care.

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. Each hospital will have a unique phone number to call.

Discharge Planning

The last page of the Paediatric Nursing Assessment and Care Plan is for discharge planning. It provides space for details of discharge planning meetings as well as a checklist for all patient discharges. The parent carer authority discharge signature is required when children leave the ward following discharge and parents need to sign when the patient is discharged.

Communication

The majority of the issues and complaints that we deal with relate to a lack of communication. From the outset, discuss and negotiate care needs for the patient, including what will be shared and who will deliver the care. Families are encouraged to continue to be a part of the care team. This will also inform patient/parents/carers of staff expectations and may assist with minimising the power imbalance that some patient/parents/carers feel when coming to hospital.

Keep the family informed of any progression in care. Initial and regular documenting and updating of the PCB by nursing staff and the patient/carer will help to reduce any communication gap. Add items such as expectations regarding tests/theatre/care goals until next shift. Always give an opportunity for the child or family to ask questions.

Emergency Equipment Check

The emergency equipment at each bedside is to be checked by the nursing staff member caring for the patient on each shift at the commencement of their shift. This includes:

1. Oxygen and air and the oxygen outlet MUST have a 15L flow meter and nipple attached. Test gauge to see that the black ball goes to 15L.
2. Hudson masks available in both adult and paediatric sizes.
3. Suction gauge, tubing and canister and disposable bag – the suction equipment MUST maintain a seal when gauge is turned on and tubing blocked. Turn suction on and place fingertip over the end of the suction tubing to check that there is adequate suction pressure. Pressure generated should be sufficient to adhere the fingertip to the tubing. Occluded Suction pressure for an emergency should not exceed 100mmHg.
4. Adult yanker sucker MUST also be at the patient's bedside.

5. Other items may include a paediatric yanker sucker and a y-site suction catheter.

ALERT
KNOW the location of an ambi-bag on the ward/unit. Check to see the outer bag is sealed, if it is not sealed, check the contents to ensure all parts are present. If you do not know, get another sealed bag and compare the contents.

1. Omission

If charts cannot be completed during the admission process then omissions and reasons why need to be recorded in the healthcare record.

2. Location of documents

The assessment forms were not developed as a single booklet as some information can be at the bedside and some cannot. The Paediatric Risk Assessment form is to be kept in the patient's healthcare record and NOT at the bedside as it contains child protection screening information.

3. Basic requirement for an admission documentation
    a) Date (using dd/mm/yyyy) and time (using a 24-hour clock) of arrival to the ward.
    b) Reason for admission.
    c) Observation of current state/condition on arrival to the area.
    d) Accurate statements of clinical interactions between the patient/client and their significant others, and the health service relating to assessment; diagnosis; care planning; management/care/treatment/services provided and response/outcomes;
    e) Advice sought and provided; observation/s taken and results.
    f) Signed by the author with their printed name and designation included.
    g) Be sufficiently clear, structured and detailed to enable other members of the healthcare team to assume care of the patient/client or to provide ongoing service at any time.
    h) Ensure all entries are written in an objective way and do not include demeaning or derogatory remarks.
    i) Documentation to be completed at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.

Attending Medical Practitioner

The Attending Medical Practitioner (AMP) is responsible for the clinical care of the patient/client for that episode of care. They are responsible for ensuring that adequate standards of medical documentation are maintained for each patient/client under their care.
When documentation is delegated to a medical practitioner such as an Intern, Resident or Registrar, the AMP remains responsible for ensuring documentation is completed to an appropriate standard so as to satisfy their professional obligations.
The AMP should review the preceding medical entries every 2 days and make a written entry in the healthcare record (print name, signature, designation and date/time) to confirm they have been read at the same time as they are reviewing the medical management plan for the patient/client. This ensures that care remains current and clinically appropriate, consistent with the AMP's duty of care to the patient/client.

Documentation by Medical Practitioners

Documentation by medical practitioners must include the following:
a) Medical history, evidence of physical examination.
b) Diagnosis/es (as a minimum a provisional diagnosis), investigations, treatment, procedures/interventions and progress for each treatment episode.
c) A principal diagnosis must be reported for every episode of admitted patient care.
d) Medical management plan.
e) Where an invasive procedure is performed and/or an anaesthetic is administered, a record

of the procedure including completion of all required procedural checklists. Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required.

f) Comprehensive completion of all patient/client care forms.
g) A copy of certificates, such as Sick and Workers Compensation Certificates, provided to patients/clients must be retained in the patient/client's healthcare record.

Documentation by Nurses and Midwives

Documentation by nurses and midwives must include the following:

a) Care/treatment plan, including risk assessments with associated interventions.
b) Comprehensive completion of all patient/client care forms.
c) Any significant change in the patient/client's status with the onset of new signs and symptoms recorded. Including any clinical reviews or rapid responses.
d) If a change in the patient/client's status has been reported to the responsible medical practitioner, documentation of the name of the medical practitioner and the date and time that the change was reported to him/her.
e) Documentation of medication orders received verbally, by telephone/electronic communication including the prescriber's name, designation and date/time.

Short Stay Patients

The requirements for a short stay patient do not differ. All of the above mentioned actions and documentation MUST occur for ALL paediatric patients.

Implementation, Monitoring Compliance and Audit

The level of implementation, monitoring or compliance and audit will be based on the risk rating of the document.

1. The document will be communicated through the CE News, Children Young People and Families Services Communication email. An updated implemented strategy to be developed at each site depending on the current level of compliance. Compliance can be reviewed using the audit tool.
2. The document will be monitored for effectiveness and compliance via the annual Paediatric Acute Care Audit.
3. Local implementation of this document will be undertaken at the direction of the local management team.

References

Paediatric Risk Assessment and Paediatric Nursing Assessment with Care Plan charts: Explanatory Notes

Consultation

Allied Health – Rosemary Day, Bianca Da Silva, Sonia Hughes
Armidale - Dr Elizabeth Cotterell, Katherine McDonnell, Helen Stevens
John Hunter Children's Hospital – Dr Julie Adamson, Jared Allen, Margaret Allwood, Erina Anderson, Helene Anderson, Dr Frank Alvaro, Jessica Ball, Dr Rani Bhatia, Kristy Bradbery, Sam Bullen, Natalie Butchard, Jaime Chase, Kristy Chesworth, Leanne Crittenden, Alexandria Davies, Jo Davis, Lee McDonald, Kathryn Elston, Scott Erskine, Matthew Frith, Catherine Grahame, Vincent Gough, Lee Grant, Margaret Hayes, Kathryn Jesson, Molly Jones, Dawn Kemp, Leanne Lehrle, Samantha Lemke, Dina Lindemann, Derek Lowe, Nicole Laybutt, Amy Maccue, Bronwyn Mckinley, Flora Masens, Eloise Miller, Ellen Mills, Erin Moore, Sam Ness-Wilson, Justine Parsons, Stacey Parke, Helen Petrovic, Rachael Phillips, Dr Sharon Ryan, Jason Simpson, Sandra Stone, Senior Paediatric Registrar, Jeanette Symington, Lynn Walker, Jennifer Wilson, Paul Widseth, Shalome Wright

Maitland – Dr David Rogers, Megan Brown, Lisa Gouldson, Rhonda Winskill
Manning – Dr Shelley Deane, Dr Dylan Wesley, Dr Maureen Van Rossum du Chattel, Dr Thomas Campbell, Sandra Babekuhl, Tracey Laidlaw,
Tamworth – Dr Genaro Domingo, Terese Madden

Appendix 1: Paediatric Risk Assessment Tool (PRAT)

NSW GOVERNMENT | Health

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAEDIATRIC RISK ASSESSMENT
(Incorporating GLAMORGAN Pressure Injury tool)

ALL sections to be completed by admitting nurse on ALL children on admission and filed in patient's medical records.

Admitting Nurse: ______________________

Designation of Admitting Nurse: ______________________

Signature: ______________________ Date: ____/____/____

Social History

Name of the child's parent/ authorised carer: ______________________

Contact Details for the child's parent/ authorised carer: ______________________

Family Structure (who does the child live with): ______________________

Are there any custody issues / court orders/AVOs/ visitor restrictions in place related to this child or their family? ☐YES ☐NO

Have copies of documentation related to custody issues / court orders/ visitor restrictions been obtained? ☐YES ☐N/A

Is the child in out-of-home-care (OOHC)? ☐YES ☐NO Contact details (organisation, Case worker): ______________________

Details (including care status if in OOHC): ______________________

Paediatric Risk Assessment	Action required
Does the child have an ID band checked and applied? ☐ WHITE ☐ RED	Reasons for red:
Does the child have their immunisations up-to-date? ☐YES ☐NO	*Consider catch-up schedule*
Standard Paediatric Observation Chart (select): <3mths ☐ 3-12 mths ☐ 1-4 years ☐ 5-11 years ☐ 12+years ☐	

Behavioural, Emotional, Mental Health Risk Assessment	No	Yes	Action required
Does the child have any behavioural, emotional or mental health problems? Details:			*Consider referral to CYMHS for mental health risk assessment*

Infection Prevention & Control Risk Assessment	No	Yes	Action required
Has the child had exposure to diseases such as chicken pox, measles or whooping cough in the last 3 weeks?			*Determine if isolation with transmission based precautions are required*
Does the child present with any other known or suspected infections or conditions that require infection control precautions during this admission?			*Determine if isolation with transmission based precautions are required*
Does the child have a history of multi resistant organisms e.g. MRSA, VRE, MRAB?			*Determine if isolation with transmission based precautions are required*
Does the child have a condition that increases their risk of infection such as immunocompromise, diabetes?			*Determine if isolation with transmission based precautions are required*

Nutritional Risk Assessment	No	Yes	Action required
Has the child unintentionally lost weight lately?			If yes to any: • Strict food intake record • Weigh twice weekly Two or more 'yes' responses to generate a referral to a dietician Referral date: ___/___/_____
Has the child had poor weight gain over the last few months?			
Has the child been eating/ feeding less in the last few weeks?			
Is the child obviously underweight/ significantly overweight?			
Is the child's diet appropriate for their developmental age?			

PAEDIATRIC RISK ASSESSMENT (Incorporating GLAMORGAN Pressure Injury tool)

SMR060.994

NSW GOVERNMENT | Health

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CHILD PROTECTION

OFFICE USE ONLY

DO NOT ask questions below of child, young person or family – *observe and listen* - this is your assessment as the healthcare professional

Child Safety, Welfare and Wellbeing Risk Assessment	No	Yes	Action required
Do you, as the nurse caring for the patient, have any concerns for this child/young person regarding;			If answered **YES** to any of these questions, or if concerns arise during the admission; **USE MANDATORY REPORTER GUIDE AND ACTIVATE LOCAL CHILD PROTECTION RESPONSE/ PROCEDURE** **Online Mandatory Reporter Guide (MRG)** http://www.keepthemsafe.nsw.gov.au/reporting_concerns/mandatory_reporter_guide Contact: Health Child Wellbeing Unit - **1300 480 420 (8:30am – 5:30pm M-F)**; and/or Children's Hospitals Child Protection Units (24hour): **Westmead - 02 9845 2434** **Randwick - 02 9832 1412/3** **John Hunter – 02 4921 3000** **Arrange further assessment, if required:** e.g. Social work consult/specialist consult; Suspected Child Abuse and Neglect (SCAN) Medical Protocol **Report suspected Risk of Significant Harm as per MRG outcome:** Child Protection Helpline **133 627** or https://kidsreport.facs.nsw.gov.au **Link family to support:** Family Referral Services http://www.familyreferralservice.com.au/
Physical abuse (bruising on the face head or neck; burn marks or scalds; severe head injury; bone fractures or dislocations; especially in children under two years of age) E.g. inappropriate delay in presentation, injury not explained / not consistent with stated cause development, child under 12 months (or non-mobile) with fracture or bruising, recurrent injuries or ingestions based on available medical records of this child/sibling			
Neglect E.g. concerns regarding inappropriate level of supervision for age/ development, persistent inattentiveness of parent/carer, homelessness, nutrition i.e. malnutrition or morbid obesity, poor hygiene/clothing, failure to follow medical advice or mental health care, school non-enrolment/ frequent absences			
Sexual abuse (potential indicators include trauma to the breasts, buttocks, lower abdomen or thighs including bite/burn marks; trauma to the genital region) E.g. you become aware of sexual abuse or have concerns about sexual contact, medical findings suspicious for sexual abuse, child/young person's observed sexualised behaviour makes you worry that he/she may be a victim of sexual abuse			
Psychological harm E.g. child/young person has been exposed to domestic violence, severe parent/carer mental health issues and/or behaviours that are persistent and have a negative impact on child/young person's development, self-esteem and self-worth; you become aware of an underage marriage or similar union that has occurred or is being planned			
Child/Young person is a danger to self and/or others E.g. recently attempted, threatened or planned suicide; self-harmed and/or consumed alcohol or drugs, violently injured or threatened to violently injure others **AND** parent/carer is refusing or unable to provide intervention, you are unable to locate parent/carer, or parent/carer actively aggravating the child/young person's emotional or aggressive state			
Parent/carer wanting to relinquish care E.g. parent/carer stating that he/she is no longer willing to provide shelter/ food/supervision for child/young person, effective immediately, or parent/ carer is stating that they are unwilling or unable to resume care on discharge			
Concerns that actions and behaviours of the parent/carer may be impacting on the child/young person (controlling; harsh punishment; verbally abusive and violent) E.g. substance abuse, mental health and/or domestic violence is present			

Details of concerns and action e.g. referral to social worker / Child Wellbeing Unit contact / consult with specialist service / conversations to clarify or respond to risk issues: Notes:

- Child protection reporting can be documented elsewhere in the patient notes
- MRG report to be printed and placed in patient notes

Acknowledgements to:
Children's Healthcare Network Paediatric Clinical Nurse Consultants Group, NSW Kids and Families, Miami Children's Hospital Humpty Dumpty Falls Prevention Program. The Children's Hospital at Westmead Clinical Excellence Commission, Curley, M.A.Q., Razmus, I.S., Roberts, K.E., Wypij, D. Predicting Pressure Ulcer Risk in Pediatric Patients: The Glamorgan Scale. Nursing Research. 52(1):22-33, January/February 2003.

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR060994

SMR060994

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAEDIATRIC FALLS RISK

Initial Falls Risk Assessment MUST be reassessed if condition changes (Adapted from the Miami Children's Hospital *Humpty Dumpty Falls* Prevention Program)	Score (circle if YES)
Age	
< 3 years old	4
3 years to < 7 years old	3
7 years to < 13 years old	2
13 years +	1
Gender	
Male	2
Female	1
Diagnosis	
Neurological diagnosis	4
De-conditioned/alteration in oxygenation (e.g. respiratory diagnosis, dehydration, anaemia, syncope/dizziness disorder)	3
Psych/behavioural	2
Other diagnosis	1
Cognitive Impairment	
Not aware of limitations	3
Forgets limitations	2
Oriented to own ability	1
Environmental Factors	
History of falls OR infant - toddler placed in bed	4
Patient uses assistive devices OR infant - toddler in cot	3
Patient placed in bed	2
Outpatient area	1
Patient has had Surgery/Deep Sedation	
Within 24 hours	3
Within 48 hours	2
More than 48 hours/none	1
Medication Usage	
Multiple usage of sedatives (excluding ICU); hypnotics; barbiturates; antidepressants; laxatives; diuretics; narcotics	3
One of the medications listed above	2
Other medications/none	1
Total Score (high fall risk = score ≥ 12)	

Action Required

ON ADMISSION

- *Educate child/parents/carers about the potential fall risk and interventions and provide information*
- *Educate child/parents/carers on how to use the call bell - ensure nurse call bell and light is within easy reach*
- *Document that a plan of care has been discussed with the child/parents/carer in clinical progress notes*
- *Bed/cot rails up. Assess for any gaps where a child could be injured or trapped; consider the use of additional safety precautions, such as bolster*
- *Place child in developmentally appropriate sized bed (may require low bed), brakes on*
- *Ensure child has non-skid footwear and appropriate clothing to prevent tripping*
- *Care actions relevant for all children as a component of ongoing clinical care*
- *Assess toileting needs and assist as needed*

ROUTINE CARE

Care actions relevant for all children as a component of ongoing clinical care

- *Assess toileting needs and assist as needed*
- *Bed heads and foot ends must be in place on all beds at as per hospital protocol*
- *If child mobilises with IV pole, ensure equipment is placed close to the centre of the pole, and IV lines*
- *are secure*
- *Ensure environment is clear of clutter and bed area is clear of trip hazards*
- *Curtains should be pulled back to enable full view of child, unless otherwise indicated*
- *Ensure adequate lighting and leave nightlight on where appropriate*
- *Keep room door open at all times unless specified isolation precautions are in use*

Additional considerations for high risk (score of 12 or above) patients:

- *At clinical handover communicate high fall risk status and interventions in place*
- *At a minimum check the child every hour if they are unattended*
- *Accompany the child when they are ambulating*
- *Consider moving child closer to nurses' station*
- *Assess need for 1:1 general observation*
- *Review medication administration times for children*
- *Engage child's parents/carers in falls prevention interventions*

DOCUMENT CARE ACTIONS IN HEALTHCARE RECORD

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NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAEDIATRIC PRESSURE INJURY

(Incorporating GLAMORGAN Pressure Injury tool)

Initial Pressure Injury Risk Assessment - MUST be reassessed if condition changes	Tick when completed	Action Required: Findings/Action Required (e.g. heels, elbows, IVC, oxygen tubing, oxygen saturation probes and traction)
Visual Skin inspection undertaken to assess for skin integrity		

MODIFIED GLAMORGAN PRESSURE INJURY RISK ASSESSMENT SCALE (0-18 years)	Score (circle if YES)	
Risk Factor (If data such as serum albumin or haemoglobin is not available, write NK – not known and score 0)		
MOBILITY Child cannot be moved without great difficulty or deterioration in condition / under general anaesthetic >2 hours	20	
Unable to change his/her position without assistance /cannot control body movement	15	
Some mobility, but reduced for age	10	
Normal mobility for age	0	
Significant anaemia (Hb <9g/dl) *- if data unavailable write NK (not known) and score 0*	1	
Persistent pyrexia (temperature > 38.0°C for more than 4 hours)	1	
Poor peripheral perfusion (cold extremities/ capillary refill > 2 secs / cool mottled skin)	1	
Inadequate nutrition (discuss with dietician if in doubt)	1	
Low serum albumin (< 35g/l) *- if data unavailable write NK (not known) and score 0*	1	
Weight less than 10th centile	1	
Incontinence (inappropriate for age)	1	
Total score for mobility section	(M)	
DEVICES Equipment / objects / hard surface pressing or rubbing on skin (D)	(D) 10	

10+ At risk

- *Inspect skin at least twice a day.*
- *Relieve pressure by helping child to move at least every 2 hours.*
- *Use an age and weight appropriate pressure redistribution surface for sitting on/ sleeping on.*

15+ High risk

- *Inspect skin with each positioning.*
- *Reposition equipment and devices at least every two hours.*
- *Relieve pressure before any skin redness develops.*
- *Use an age and weight appropriate pressure redistribution surface for sitting on/sleeping on.*

20+ Very high risk

- *Inspect skin at least hourly.*
- *Move or turn if possible, before skin becomes red.*
- *Ensure equipment / objects are not pressing on the skin.*
- *Consider using specialised pressure relieving equipment.*

NOTES:
1. All risks to be communicated at clinical handover
2. Educate child/ parent about potential pressure injury risks and interventions
3. Escalate care and refer

NOTE: It should however be remembered that the risk assessment tool is only an aid to identify patients at risk and it is not intended as a substitute for nursing observation and skill in the management of patients.

DO NOT PRINT

Appendix 2: Paediatric Nursing Assessment and Care Plan

NSW GOVERNMENT Health

Facility:

PAEDIATRIC NURSING ASSESSMENT AND CARE PLAN

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Admission (complete on all patients on admission to the ward)

Date of Admission: ____/____/____ Expected Date of Discharge (EDD): ____/____/____

Reason for admission: ____

Past Medical History (disabilities, syndromes, chronic conditions): ____

Orientation to Ward (tick when discussed with parent / carer / child)

Parent / Family accommodation		Patient call system	
Visiting Hours		Process for escalating care discussed with family	
Meal Times / Food Services		Medications / NO self-medicating	
Ward Routine		Rights & Responsibilities and Privacy brochures (NSW Health)	
Unit Manager / Nurse-in-charge		Family advised of EDD	
Telephone / mobiles/ TV		Belongings & Valuables	
Parking / Transport		Smoking Regulations	
Relevant fact sheet given		Interpreter services contacted (if required)	
Orientation to the ward		Aboriginal Liaison Officer contacted (if appropriate)	

Nursing Assessment

Weight *(bare weight under 12 months)*: ____ kg Height / Length: ____ cm Head circumference *(less than 2years)*: ____ cm

Gestation at Birth: ____ /40 weeks *(optional)* Weight at Birth *(optional)*: ____ grams

Breast Fed ☐ Formula Fed ☐ Formula Type____ Volume & Frequency: ____ Teat: ____

Quantity: ____ Frequency: ____

Nutritional needs and assistance required (food allergies / restrictions, lactation assistance, feeding regime, NGT or PEG feeds): ____

Regular Medications: ____

Toilet trained: ☐ DAY ☐ NIGHT Details: ____

Wears nappies: ☐ DAY ☐ NIGHT Details: ____

Additional assistance with elimination (bowel routines, enemas, catheters, stomas): ____

Sleep routine: DAY ____ NIGHT ____

Safety advice given on *(tick as appropriate)*:

Bed lowered: ☐ Cot sides / bed rails raised: ☐ SIDS & Kids Safe Sleeping: ☐ Co-sleeping / Co-bedding: ☐

Year at School: ____ Child's educational needs (while in hospital): ____

Is there anything that you would like to let us know that may assist us in providing care to your child? ____

ADMITTING NURSE NAME: ____ ADMITTING NURSE SIGNATURE: ____

DESIGNATION: ____ Date: ___/___/____ Time: ___:____ hours

NO WRITING Page 1 of 4

PAEDIATRIC NURSING ASSESSMENT AND CARE PLAN SMR060.997

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NSW GOVERNMENT Health

Facility:

PAEDIATRIC NURSING ASSESSMENT AND CARE PLAN

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Discharge Planning

Estimated Date of Discharge (EDD): ____/____/____

Does the patient require a discharge planning meeting: ☐ YES ☐ NO

☐ Discharged against medical advice

Meeting date: ____/____/____

Details: ____

Completed by (name): ____ Designation: ____

Please ensure the following have been reviewed / explained to patient and / or parent / authorised carer prior to discharge:

- Medical discharge summary given ☐ YES ☐ NO Comment ____
- Discharge script / medications – explained fully ☐ YES ☐ NO ☐ N/A
- Medication reconciliation ☐ YES ☐ NO ☐ N/A
- Medical certificates – patient and parent / carer ☐ YES ☐ NO ☐ N/A
- Medical equipment required at home ☐ YES ☐ NO ☐ N/A
- Parent / carer aware of follow up appointments ☐ YES ☐ NO ☐ N/A
- Other ____

Parent / Authorised Carer Discharge Signature

I ____ *(print name)* am the parent / authorised carer of ____ *(print name)* and I accept responsibility for his/her discharge and I have received and understood the relevant healthcare information.

Parent / authorised carer name: ____ Signature: ____

Relationship to child: ____ Date: ___/___/____ Time: ___:____ hours

Witness name: ____ Signature: ____

Designation: ____ Date: ___/___/____ Time: ___:____ hours

Page 4 of 4 NO WRITING

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SMR060997

NSW GOVERNMENT Health

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR060997

PAEDIATRIC NURSING ASSESSMENT AND CARE PLAN

Planned Care (complete on all patients on arrival to the ward and revise WHEN CARE CHANGES)

Nursing care	Initial Care: Date: __/__/__	Revised Care: Date: __/__/__	Revised Care: Date: __/__/__	Revised Care: Date: __/__/__
Checklist / clinical pathway being used (if any)				
Interval of standard observations (as per SPOC)				
Oxygen therapy	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES
Special observations in addition to SPOC (e.g. PCA, BGL, neuro, neurovascular, traction)				
Nutritional needs (e.g. diet, frequency, method & assistance)				
Toileting (e.g. nappies / toilet training, assistance)				
Hygiene (e.g., skin integrity, assistance)				
Mobility (e.g. aids, assistance)				
Pressure area care	Score: ______ Risk level: ______	Score: ______ Risk level: ______	Score: ______ Risk level: ______	Score: ______ Risk level: ______
Skin inspection	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES
Falls risks	Score: ______ ☐ Routine ☐ High risk	Score: ______ ☐ Routine ☐ High risk	Score: ______ ☐ Routine ☐ High risk	Score: ______ ☐ Routine ☐ High risk
Safety and security (e.g. cot sides / bed rails, SIDS & Kids Safe Sleeping)				
Infection prevention & control - standard & transmission based precautions	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne
PIVC / CVAD / IVT Care				
Other care				
Care discussed with parent / carer	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES
Assigned nurse to sign when care revised	Sign: Time: ___:___hr	Sign: Time: ___:___hr	Sign: Time: ___:___hr	Sign: Time: ___:___hr

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NH700048 041115

Page 2 of 4 NO WRITING

NSW GOVERNMENT Health

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAEDIATRIC NURSING ASSESSMENT AND CARE PLAN

Planned Care (complete on all patients on arrival to the ward and revise WHEN CARE CHANGES)

Nursing care	Initial Care: Date: __/__/__	Revised Care: Date: __/__/__	Revised Care: Date: __/__/__	Revised Care: Date: __/__/__
Checklist / clinical pathway being used (if any)				
Interval of standard observations (as per SPOC)				
Oxygen therapy	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES
Special observations in addition to SPOC (e.g. PCA, BGL, neuro, neurovascular, traction)				
Nutritional needs (e.g. diet, frequency, method & assistance)				
Toileting (e.g. nappies / toilet training, assistance)				
Hygiene (e.g., skin integrity, assistance)				
Mobility (e.g. aids, assistance)				
Pressure area care	Score: ______ Risk level: ______	Score: ______ Risk level: ______	Score: ______ Risk level: ______	Score: ______ Risk level: ______
Skin inspection	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES
Falls risks	Score: ______ ☐ Routine ☐ High risk	Score: ______ ☐ Routine ☐ High risk	Score: ______ ☐ Routine ☐ High risk	Score: ______ ☐ Routine ☐ High risk
Safety and security (e.g. cot sides / bed rails, SIDS & Kids Safe Sleeping)				
Infection prevention & control - standard & transmission based precautions	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne	☐ Standard ☐ Droplet ☐ Contact ☐ Airborne
PIVC / CVAD / IVT Care				
Other care				
Care discussed with parent / carer	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES
Assigned nurse to sign when care revised	Sign: Time: ___:___hr	Sign: Time: ___:___hr	Sign: Time: ___:___hr	Sign: Time: ___:___hr

NO WRITING Page 3 of 4

DO NOT PRINT

Appendix 3: Youth Health and Wellbeing Assessments

NSW Health

Facility:

YOUTH HEALTH AND WELLBEING ASSESSMENT (12-24 YEARS OLD)

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ___/___/___ M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR060915

For Young Person to Complete

PLEASE READ: This form tells us about things that are important for your health and wellbeing and it helps us take better care of you. You do not have to answer any questions that make you feel uncomfortable. Please talk to one of the healthcare workers if you have any questions about the form or confidentiality, or need help to fill in the form.

Date: ___/___/_____ Your name (What do you like to be called?): __________ Gender: ______

Your preferred contact details: email __________ and/or phone ______

What is your cultural background? __________

Do you have a regular doctor/GP? ☐ YES ☐ NO If Yes, name ______

Are you happy to continue to see this doctor for your health care? ☐ YES ☐ NO

General Health

Why are you being seen today? __________

Do you have a chronic illness/disability? ☐ YES ☐ NO If Yes, do you need help with your transition to adult services? ☐ YES ☐ NO

Do you have any other health issues? (if so, please list) __________

Have you ever had to stay in a hospital overnight before? ☐ YES ☐ NO

Do you have any allergies? ☐ YES ☐ NO ☐ UNSURE

Are you taking any medications (including alternatives therapies, vitamins)? ☐ YES ☐ NO Details: ______

Do you usually take these medicines as prescribed? ☐ ALWAYS ☐ USUALLY ☐ SOMETIMES ☐ NEVER ☐ N/A

When was your last dental check up? ☐ 6 month ☐ 1 year ☐ more than 1 year ☐ UNSURE

Home Environment

Where do you live?

☐ Parent home ☐ Own home ☐ Other family/Friends ☐ Supported accommodation/Refuge ☐ Foster care

☐ Sleeping rough ☐ Share housing ☐ Couch surfing (or temporary accommodation) ☐ Other ______

Do you feel safe and OK where you live? ☐ YES ☐ NO If No, why? ______

Do you have anyone who you look after at home? ☐ YES ☐ NO If Yes, who? ______

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YOUTH HEALTH AND WELLBEING ASSESSMENT (12-24 YEARS OLD) SMR060.915

NO WRITING Page 1 of 4

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NSW Health

Facility:

YOUTH HEALTH AND WELLBEING ASSESSMENT (12-24 YEARS OLD)

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ___/___/___ M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Education/ Employment

Do you attend school/TAFE/University/other education? ☐ YES ☐ NO If Yes, where? ______

Do you have a job? ☐ YES ☐ NO If Yes, for how many hours per week? ______

How do you feel you are coping with study/work? ☐ Well ☐ OK ☐ Not well ☐ Not at all

How many days of study/work have you missed in the last month? ______ Why? ______

If you don't have a job, do you have a source of money? ☐ YES ☐ NO

Eating and Nutrition

Are you ever worried about your body image, weight or diet? ☐ YES ☐ NO

Is anyone else worried about your body image, weight or diet? ☐ YES ☐ NO

If Yes, what have you done about these worries? ______

Activities and Leisure

Do you play sports or exercise? ☐ YES ☐ NO If yes, specify: ______

What activities do you enjoy in your spare time? ______

Who do you enjoy spending time with? ______

On average, how many hours a day do you spend on a computer/tablet/phone that are NOT school or work related? ______

Sleep, Mental Health and Wellbeing

What time do you usually Go to Sleep? ______ Wake Up? ______

Do you have any sleeping problems? ☐ SOMETIMES ☐ OFTEN ☐ NEVER

Are you ever worried about your mood, anxiety or mental health? ☐ YES ☐ NO

Is anyone else worried about your mood, anxiety or mental health? ☐ YES ☐ NO

Have you or are you experiencing any form of bullying including online? ☐ YES ☐ NO

In the past 12 months, have you thought about or done things, to harm yourself? ☐ YES ☐ NO

Have you ever spoken to anyone about your mood, anxiety or mental health? ☐ YES ☐ NO Who? ______

BINDING MARGIN - NO WRITING Holes Punched as per AS2828.1: 2012

SMR060915

Page 2 of 4 NO WRITING

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NSW Health

Facility:

YOUTH HEALTH AND WELLBEING ASSESSMENT (12-24 YEARS OLD)

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR060915

BINDING MARGIN - NO WRITING

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Substance Use - In the last 12 months, how frequently have you used any of the following?

Substance	Not At All	Once Only/ Rarely	Monthly or More	Weekly or More	Daily
Tobacco/Cigarettes/e-cigarettes/Vapes					
Caffeine/Energy drinks					
Alcohol					
Marijuana/Cannabis					
Hallucinogens (e.g. LSD, ketamine, mushrooms)					
Inhalants (e.g. glue, petrol, aerosols)					
Stimulants (e.g. speed, ice, cocaine)					
Pills (e.g. MDMA, ecstasy)					
Opioids (e.g. heroin, codeine, endone)					
Other:					

Have you ever injected drugs? ☐YES ☐NO
Are you ever worried about your substance use? ☐YES ☐NO
Is anyone else worried about your substance use? ☐YES ☐NO

Relationships and Sexual Health

Do you have any questions or worries about how your body is growing/puberty? ☐YES ☐NO
Are you currently in a relationship? ☐YES ☐NO
Have you ever engaged in sexual activity? ☐YES ☐NO
Which do you use to prevent sexually transmitted infection (STI) transmission? ☐Condoms ☐Other ____ ☐Nothing
Which do you use to prevent pregnancy? ☐Condoms ☐Pill ☐Implanon /IUD ☐Other ____ ☐Nothing
Do you think you or your partner could be pregnant? ☐YES ☐NO ☐N/A
Have you ever been pregnant? ☐YES ☐NO ☐UNSURE
Do you have children? ☐YES ☐NO
Have you ever been pressured to be involved in sexual activities? ☐YES ☐NO
Are you ever worried about your sexuality, sexual health and / or relationships (including contraception or pregnancy)? ☐YES ☐NO

Other Information

Do you have a trusted person you can go to if you have any problems? ☐YES ☐NO
Who is this person (e.g. friend, parent)? ____
Do you have any other worries you would like to talk about? ☐YES ☐NO
Details: ____

Completed by: ☐Young Person ☐Someone else: ____

Your name : ____

Signature ____ Date: ____/____/____

END OF QUESTIONS - THANK YOU

NO WRITING Page 3 of 4

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NSW Health

Facility:

YOUTH HEALTH AND WELLBEING ASSESSMENT (12-24 YEARS OLD)

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

For Staff to Complete

(Please refer to the resources provided in the Guideline GL2018_003 if required)

Reviewed By: ☐Nurse ☐Doctor/Medical Officer ☐Other ____

Comments:

Referrals Made:

Health Professional	Referral Made By: Name	Date	If Relevant, Patient Seen (Sign and Date)
Aboriginal Liaison Officer		/ /	
Adolescent CNC or Youth Nurse		/ /	
Adult Mental Health Service		/ /	
Carer Support Service		/ /	
Child and Adolescent/Youth Mental Health Service		/ /	
Child Protection Family Community Service		/ /	
Child Wellbeing Unit		/ /	
Dental		/ /	
Dietetics		/ /	
Drug and Alcohol		/ /	
GP		/ /	
Occupational Therapy		/ /	
Physician/surgeon		/ /	
School Teacher/Counsellor		/ /	
Sexual Health		/ /	
Social Work		/ /	
		/ /	

Was a Healthcare Interpreter used? ☐YES ☐NO

Details ____

Any concerns raised about Child Protection and/ or Domestic and Family Violence then USE MANDATORY REPORTER GUIDE AND ACTIVATE LOCAL CHILD PROTECTION RESPONSE/ PROCEDURE

Name: ____ Signature: ____

Designation: ____ Date: ____/____/____

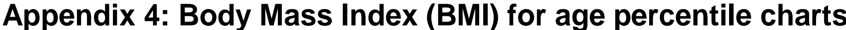
Page 4 of 4 NO WRITING

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR060915

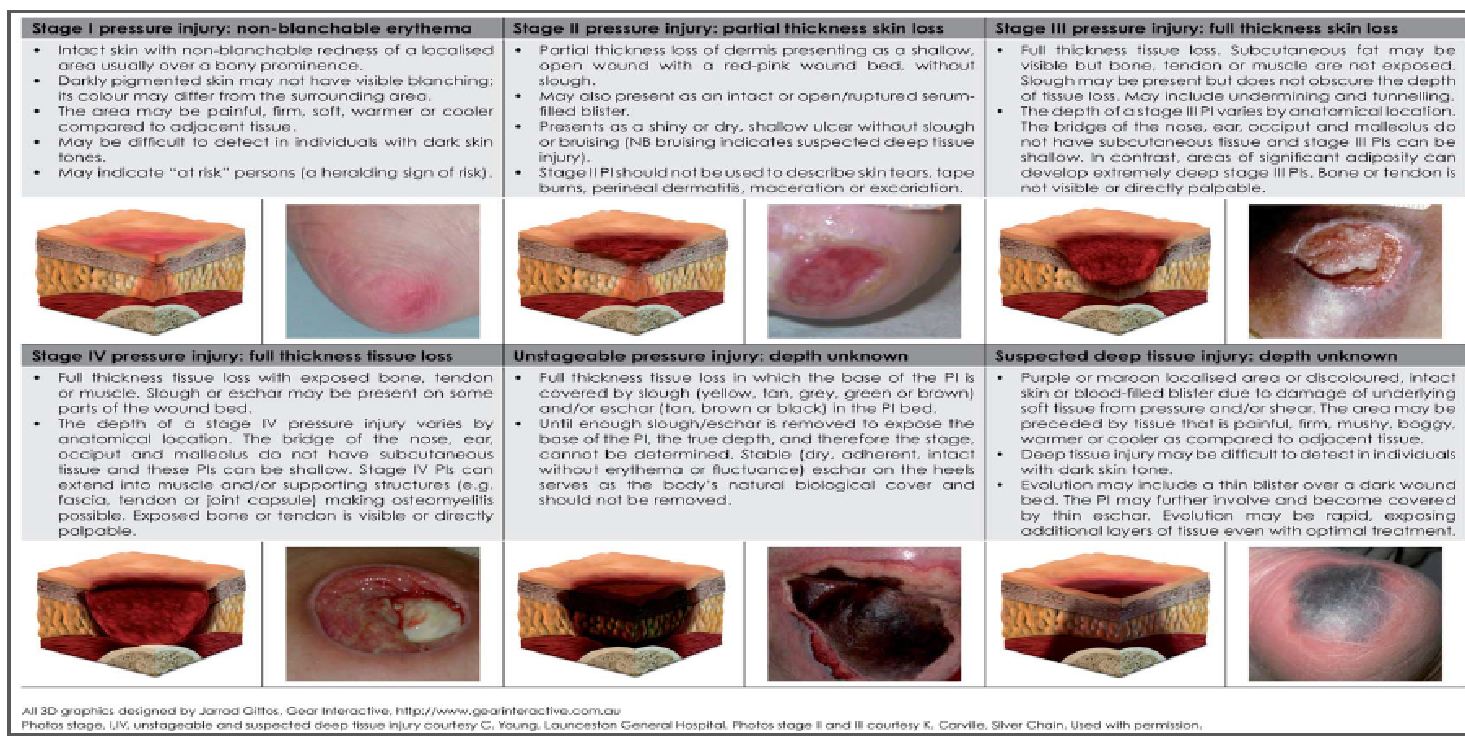
DO NOT PRINT



Appendix 4: Body Mass Index (BMI) for age percentile charts

Appendix 5: Pressure Injury Classification System

10.4 Pressure injury classification system



Stage I pressure injury: non-blanchable erythema	Stage II pressure injury: partial thickness skin loss	Stage III pressure injury: full thickness skin loss
• Intact skin with non-blanchable redness of a localised area usually over a bony prominence. • Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. • The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. • May be difficult to detect in individuals with dark skin tones. • May indicate "at risk" persons (a heralding sign of risk).	• Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough. • May also present as an intact or open/ruptured serum-filled blister. • Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury). • Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	• Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. • The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.
Stage IV pressure injury: full thickness tissue loss	**Unstageable pressure injury: depth unknown**	**Suspected deep tissue injury: depth unknown**
• Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. • The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.	• Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed. • Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.	• Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. • Deep tissue injury may be difficult to detect in individuals with dark skin tone. • Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

All 3D graphics designed by Jarrad Gittos, Gear Interactive, http://www.gearinteractive.com.au
Photos stage, I,IV, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital. Photos stage II and III courtesy K. Carville, Silver Chain. Used with permission.

Based on National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2009, Washington DC: NPUAP cited in Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Abridged Version, AWMA; March 2012. Published by Cambridge Publishing, Osborne Park, WA.

Glossary

Acronym or Term	Definition
AMO	Admitting Medical Officer
AVPU	Alert, Voice, Pain, Unresponsive
BGL	Blood Glucose Level
BP	Blood Pressure
CAP	Clinical Applications Portal
CERS	Clinical Escalation Response System
Core observations	The core set of physiological observations for children as a minimum are: respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, level of consciousness, pain score. Blood pressure is required at least once during the admission (on admission then continuing if indicated by clinical condition).
DMR	Digital Medical Records
DOB	Date of Birth
ED	Emergency Department
FLACC	Face, Legs, Activity, Cry, Consolability scale
GCS	Glasgow Coma Score
GP	General Practitioner
HC	Head Circumference
HNELHD	Hunter New England Local Health District
HR	Heart Rate
HT	Height
IMS+	Incident Information Management System
iPM	Isoft Patient Management System
JHCH	John Hunter Children's Hospital
LOC	Level of Consciousness
MRN	Medical Record Number
NMBA	Nursing and Midwifery Board of Australia
P	Pulse
PARU	Post Anaesthetic Recovery Unit
PEDOC	Paediatric Emergency Department Observation Chart
PNST	Paediatric Nutrition Screening Tool
PRAT	Paediatric Risk Assessment Tool
QARS	Quality Audit Reporting System
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
SpO_2	Peripheral capillary oxygen saturation
SPOC	Standard Paediatric Observation Chart
T	Temperature
UA	Urinalysis
VBG	Venous Blood Gas
WT	Weight