EXPLANATORY NOTES
Paediatric Risk Assessment and Paediatric Nursing Assessment with Care Plan charts

Background
The ACT/NSW Paediatric & Children’s Healthcare Network Clinical Nurse Consultants group identified a need for standardised paediatric risk/nursing assessment charts for acute paediatric in-patient units:
- To meet the National Safety and Quality Health Service (NSQHS) Standards
- To reduced unwarranted clinical variation in the care for children across NSW
- To meet the clinical needs common to acute paediatric wards
- To avoid duplication and reduce the number of assessment charts
- To include mandated tools (e.g. falls, pressure injury, nutrition)

NSW Health Office of Kids and Families facilitated a State working party to develop the charts, with representation from tertiary and non-tertiary facilities including rural and remote sites across NSW. This group developed charts aimed for state-wide consistency for children and adolescents admitted to acute paediatric in-patient areas.

Local governance
Local Health Districts (LHDs) and Specialty Health Networks (SHNs) are required to provide governance for the integration of the charts into local clinical practice as part of the implementation process, including education and auditing of the paediatric assessment charts.

Target patient group
- The chart is intended for use with PAEDIATRIC patients cared for in paediatric in-patient areas.
- The chart is primarily for use in all non-tertiary paediatric and general acute paediatric wards.
- Paediatric sub-specialty areas in Specialist Children’s Hospitals may require additional clinical assessments on additional or alternative charts.
- The chart is NOT to be used for adult patients.

Target education group
- Nursing staff on paediatric wards and other paediatric inpatient areas.
The charts

There are 2 paediatric assessment charts:

- **Paediatric Risk Assessment Form** (incorporating either the modified Glamorgan or Braden Q pressure injury scale)
- **Paediatric Nursing Assessment & Care Plan** *(Paediatric Nursing Care Plan - extended stay form available for longer admissions)*

The charts were not developed as a single booklet as some information can be at the bedside and some information cannot.

**Bedside**

Paediatric Nursing Assessment & Care Plan can be used as a working document in the bedside notes during admission and filed in the healthcare record following discharge (refer to current ward practice).

**Healthcare record**

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.

The paediatric assessment charts are to be completed by the admitting nurse on patients admitted to an acute paediatric in-patient area. All sections of the charts are mandatory. Nursing staff need to use clinical judgement to assess if the situation is appropriate to complete the assessment forms immediately upon admission. If charts cannot be completed during the admission process then omissions and reasons why need to be recorded in the healthcare record.

**Electronic Medical Records charts**

The information in the paper copies and the information required in EMR2 are the same. The formats for each vary but not the information. You need to complete EMR or paper copies – as per local facilities procedure.
PAEDIATRIC RISK ASSESSMENT CHART

The chart contains child protection information and **MUST NOT** be kept at the bedside. It incorporates several mandatory risk assessment tools including; pressure injury, falls, nutritional screening as well as child protection. Additional risk assessment information relates to; social history, risk assessment, behaviour, emotion, mental health and infection control.

**Paediatric Falls Assessment**

This is an initial assessment of a child’s falls risk and is adapted from the *Miami Humpty Dumpty Falls* risk assessment tool. This falls assessment is to be used in conjunction with the CEC Paediatric Falls risk program and education. Program information available at: [http://www.cec.health.nsw.gov.au/programs/falls-prevention/paed-falls](http://www.cec.health.nsw.gov.au/programs/falls-prevention/paed-falls). The initial and subsequent scores and level of risk are to be recorded in the patient’s care plan. The *Action* column provides information for clinicians on the appropriate care required in response to an identified falls risk. Documentation of all actions taken should be made in the patient’s health care record.

**Paediatric Pressure Injury Assessment**

This is an initial assessment of a child’s pressure injury risk assessment using either the modified Glamorgan or Braden Q scale. There are **two versions of the Paediatric Risk Assessment chart** available;

1. one incorporating the modified *Glamorgan* pressure injury tool
2. the other incorporating the *Braden Q* pressure injury tool

As part of the pressure injury assessment clinicians must visualise skin and document integrity on the patient’s care plan. The initial and subsequent scores and level of risk are also to be recorded in the care plan. The *Action* column provides information for clinicians on the appropriate care required in response to an identified risk. Documentation of actions taken should be made in the patient’s health care record.

**Child Protection**

Child Safety, Welfare and Wellbeing Risk Assessment part of the chart is adapted from the Mandatory Reporter Guide. This part of the chart is **for staff use only**. It is a health care professional observation and assessment form. **Parents/carers are NOT to be asked these questions.** This is an initial assessment on admission. As a mandatory reporter all staff MUST re-assess if any concerns arise during the admission. The *Action required* column provides information to guide staff about appropriate action to be taken and relevant contact details. There is an area for staff to write concerns at the bottom of the page.
PAEDIATRIC NURSING ASSESSMENT AND CARE PLAN CHART

This chart can be kept at the bedside or as per usual practice for the ward. It is to be completed on admission to the ward and includes information about; admission details, orientation to the ward, the nursing assessment and nursing care plan.

Parent information brochures

The orientation to the ward section refers to several brochures to be made available to parents/carers. These can be found at:

- **Your Health Rights and Responsibilities – A Guide for Patients, Carers & Families**

- **What you need to know about Information Privacy**

- **Youth Friendly Confidentiality Resources - We keep it zipped – we provide a confidential service for young people**

Paediatric nursing care plan

Patient care plans are to be completed initially on admission and *updated when care changes*. This may be more than once during a shift for example, when a child is pre and post-operative during a shift, or may not require changing at all during a shift. There is no requirement to routinely sign each shift unless there are changes to the care required during that shift.

There are several tick box sections to make the nursing care plan simple to complete. For the falls risk and pressure area care sections of the care plan document score and risk actions required. Extended stay care plans are available as a single additional page for longer admissions.

Discharge planning

The last page of the chart 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.

If you require further information regarding implementation of the paediatric assessment charts you can contact your local paediatric clinical nurse consultant or Catherine Jones, Paediatric Healthcare Team, NSW Health Office of Kids and Families. [cjone@doh.health.nsw.gov.au](mailto:cjone@doh.health.nsw.gov.au)