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

PAEDIATRIC NURSING ASSESSMENT AND CARE PLAN SMR060.997

DO NOT PRINT

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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: ____________________

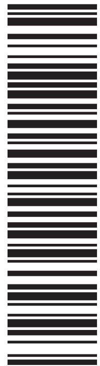
Designation: ____________________ Date: ___/___/_____ Time: ___:_____ hours

NO WRITING

BINDING MARGIN - NO WRITING

Holes Punched as per AS2828.1: 2012

SMR060997



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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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