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 BRADEN Q 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/ young person 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:<br>• Strict food intake record<br>• Weigh twice weekly<br>Two or more 'yes' responses to generate a referral to a dietician<br>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? | | | |

NO WRITING



PAEDIATRIC RISK ASSESSMENT (Incorporating BRADEN Q Pressure Injury tool)

SMR060.995

SAMPLE ONLY - DO NOT PRINT

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;<br>**USE MANDATORY REPORTER GUIDE AND ACTIVATE LOCAL CHILD PROTECTION RESPONSE/ PROCEDURE**<br>**Online Mandatory Reporter Guide (MRG)**<br>http://www.keepthemsafe.nsw.gov.au/reporting_concerns/mandatory_reporter_guide<br>Contact:<br>Health Child Wellbeing Unit - **1300 480 420 (8:30am – 5:30pm M-F)**; and/or Children's Hospitals Child Protection Units (24hour):<br>**Westmead - 02 9845 2434**<br>**Randwick - 02 9832 1412/3**<br>**John Hunter – 02 4921 3000**<br>**Arrange further assessment, if required:**<br>e.g. Social work consult/specialist consult; Suspected Child Abuse and Neglect (SCAN) Medical Protocol<br>**Report suspected Risk of Significant Harm as per MRG outcome:**<br>Child Protection Helpline **133 627** or https://kidsreport.facs.nsw.gov.au<br>**Link family to support:**<br>Family Referral Services<br>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

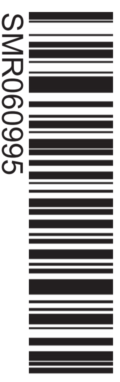
Acknowledgements to:
Children's Healthcare Network Paediatric Clinical Nurse Consultants Group, NSW Kids and Families, Miami Children's Hospital Humpty Dumpty Falls Prevention Program. The Children's Hospital at Westmead Clinical Excellence Commission, Curley, M.A.Q., Razmus, I.S., Roberts, K.E., Wypij,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



NO WRITING

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING



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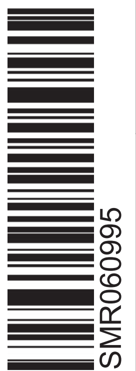

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Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NSW GOVERNMENT Health

**Facility:**

# PAEDIATRIC FALLS RISK

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

| 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***

NH700049 041115



NO WRITING

NSW GOVERNMENT Health

**Facility:**

# PAEDIATRIC PRESSURE INJURY

**(Incorporating BRADEN Q Pressure Injury tool)**

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

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

**Initial Pressure Injury Risk Assessment - MUST be reassessed if condition changes**

| Visual Skin inspection undertaken to assess for skin integrity | *Tick when completed* | ***Findings/Action Required (e.g. heels, elbows, IVC, oxygen tubing, oxygen saturation probes and traction)*** |
|---|---|---|
| | | |

**The BRADEN Q SCALE PRESSURE INJURY RISK ASSESSMENT (0-18 years)**

| **Intensity and Duration of Pressure** | | | | | **Score** |
|---|---|---|---|---|---|
| **Mobility**<br>The ability to change and control body position | **1. Completely immobile:**<br>Does not make even slight changes in body or extremity position without assistance. | **2. Very Limited:**<br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently. | **3. Slightly Limited:**<br>Makes frequent though slight changes in body or extremity position independently. | **4. No Limitations:**<br>Makes major and frequent changes in position without assistance. | |
| **Activity**<br>The degree of physical activity | **1. Bed fast:**<br>Confined to bed | **2. Chair fast:**<br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted in to chair or wheelchair. | **3. Walks Occasionally:**<br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | **4. All patients too young to ambulate OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours. | |
| **Sensory Perception**<br>The ability to respond in a **developmentally** appropriate way to pressure related discomfort | **1. Completely Limited:**<br>Unresponsive (flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body surface. | **2. Very Limited:**<br>Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has sensory impairment which limits the ability to feel pain or discomfort over ½ of body. | **3. Slightly Limited:**<br>Responds to verbal commands, but cannot always communicate discomfort or need to be turned **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. | **4. No Impairment:**<br>Responds to verbal commands. Has no sensory deficit, which limits ability to feel or communicate pain or discomfort. | |
| **Tolerance of the Skin and Supporting Structure** | | | | | |
| **Moisture**<br>Degree to which skin is exposed to moisture | **1. Constantly Moist:**<br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned. | **2. Very Moist:**<br>Skin is often, but not always moist. Linen must be changed at least every 8 hours. | **3. Occasionally Moist:**<br>Skin is occasionally moist, requiring linen change every 12 hours. | **4. Rarely Moist:**<br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours. | |
| **Friction - Shear**<br>***Friction:*** occurs when skin moves against support surfaces<br>***Shear***: occurs when skin and adjacent bony surface slide across one another | **1. Significant Problem**:<br>Spasticity, contracture, itching or agitation leads to almost constant thrashing and friction. | **2. Problem:**<br>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. | **3. Potential Problem:**<br>Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down. | **4. No Apparent Problem:**<br>Able to completely lift patient during a position change; Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times. | |
| **Nutrition** | **1. Very Poor**:<br>NBM &/or maintained on clear fluids, or IV's for more than 5 days OR albumin < 25mg/l | **2. Inadequate:**<br>Is on liquid diet or tube feedings/TPN which provide inadequate calories and minerals for age OR albumin <30mg/l | **3. Adequate:**<br>Is on tube feedings or TPN which provide adequate calories and minerals for age | **4. Excellent:**<br>Is on a normal diet providing adequate calories for age. Does not require supplementation | |
| **Tissue Perfusion and Oxygenation** | **1. Extremely Compromised:**<br>Hypotensive (MAP <50mmHg; <40 in a newborn) **OR** the patient does not physiologically tolerate position changes. | **2. Compromised:**<br>Normotensive; Oxygen saturation may be <95 % **OR** haemoglobin may be < 10 mg/dl **OR** capillary refill may be > 2 seconds; Serum pH is < 7.40. | **3. Adequate:**<br>Normotensive; Oxygen saturation may be <95% **OR** haemoglobin may be < 10mg/dl **OR** capillary refill may be > 2 seconds; Serum pH is normal. | **4. Excellent:**<br>Normotensive, Oxygen saturation >95%; Normal Haemoglobin; & Capillary refill < 2 seconds. | |
| | | | | **TOTAL** | |

**Action Required**

***23-28 Minimal Risk***

- *Daily skin inspection*

***16-23 Patient 'At-Risk'/ Mild Risk***

- *Inspect skin at least twice a day.*
- *Relieve pressure by helping child to move at least every 2-4 hours.*
- *Reassess daily*

***13-15 Moderate Risk***

- *Inspect skin at least 4 hourly.*
- *Helping child to move at least 2 hourly or reposition child at least every 2 hours.*
- *Relieve pressure before any skin redness develops.*
- *Use an age and weight appropriate pressurere distribution surface for sitting on/ sleeping on.*

***10-12 High Risk***

- *Inspect skin with each positioning.*
- *Reposition child / equipment/ devices at least every 2 hours.*
- *Relieve pressure before any skin redness develops.*
- *Use an age and weight appropriate pressure redistribution surface for sitting on/sleeping on.*

***9 or below 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.*

NO WRITING