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?			

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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

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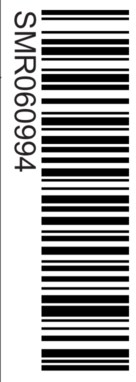
Acknowledgements to:
Children's Healthcare Network Paediatric Clinical Nurse Consultants Group, NSW Kids and Families, Miami Children's Hospital Humpty Dumpty Falls Prevention Program. The Children's Hospital at Westmead Clinical Excellence Commission, Curley, M.A.Q., Razmus, I.S., Roberts, K.E., Wypij,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

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING



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Holes Punched as per AS2828.1: 2012

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NSW Government Health

Facility:

PAEDIATRIC FALLS RISK

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / _______	M.O.
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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

NO WRITING

NSW Government Health

Facility:

PAEDIATRIC PRESSURE INJURY

(Incorporating GLAMORGAN Pressure Injury tool)

FAMILY NAME	MRN
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Initial Pressure Injury Risk Assessment - MUST be reassessed if condition changes		**Action Required**
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)***

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 > 38.0ºC 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.

NO WRITING

SIDO NOT PRINT