Assessment: Pediatrics

Site Applicability

All VCH, PHC, & PHSA sites that use Cerner. Pediatric inpatient areas

NOTE: Implementation only at Lions Gate Hospital & Squamish General Hospital to support CST Go Live.

Practice Level

RN, LPN, RPN: Foundational (basic) skills

In areas where various levels of care providers (LPN, Care Aide) are assigned to patients, care of a deteriorating patient will be assumed by a Registered Nurse.

Need to Know

By recording and comparing physical observations a nurse is able to identify problems early and reduce the likelihood of an adverse event. Due to the rapid onset of complications in the pediatric patient, frequent observations and focused assessments are necessary.

Guideline

Assessment

1. Full physical assessments (e.g. head-to-toe, systems) are conducted on all inpatients:
    a. On admission
    b. Following transfer to the unit
    c. When assuming patient assignment mid-shift from another care provider
    d. At the discretion of the nurse

2. "focused" physical assessments are conducted on all patients:
    a. With the transferring nurse at the time of patient transfers
    b. With any decline in patient status
    c. At the discretion of the nurse

3. Vital signs (heart/pulse rate (HR/P), Respiratory Rate (RR), temperature (T), Blood Pressure (BP), Pain score, oxygen saturation and pediatric early warning signs (PEWS) will be measured as per:
    a. Unit minimum Vital sign monitoring standard (see #4)
    b. Physician orders, if different from minimum standard
    c. Nursing Care plans
    d. Nursing clinical judgment
    e. As required for a particular procedure or medication

4. Frequency of Vital sign Measurement and Recording is as follows:
    a. The minimum standard of vital sign and PEWS score monitoring is every 4 hours for patients in the non critical inpatient care areas
    b. The physician may decrease the frequency of monitoring to a minimum once a day once the child's vital sign and PEWS score baseline has been established.
    a. Patients seen in ambulatory clinics will have Vital signs assessed as needed based on clinical judgement.

5. **PEWS** score is assessed in conjunction with vital signs

6. **Sepsis Screening** is to be conducted if the PEWS score increased by 2 or if the patient's temperature is above 38.5O C or below 36OC

7. Neurovital Signs (NVS) will be assessed minimum once per shift for all inpatients or as per:
    a. Physician order
    b. Nursing Care Plans
    c. Nursing clinical judgment
    d. As required for a particular procedure or medication

    NOTE: Nursing staff will perform a visual joint NVS assessment:
    a. At shift to shift handover if patient on Q2H or more frequent NVS assessment
    b. At shift to shift handover if patient on 1:1 or 2:1 nursing care
    c. If patient shows a change in GCS or other neurologic indicators that might signal a potential deterioration
    d. If patient is difficult to assess due to age or other factors
    e. If patient requires a set of NVS done by a nurse other than the primary nurse caring to the patient that shift
    f. When patient is transferred /admitted to another unit

8. Vital sign monitoring may also include oxygen saturation (SpO2), Spinal Cord Assessment and or Neurovascular Assessments. Monitoring of oxygen saturation, spinal cord assessment and/or neurovascular assessments will be initiated as per:
    a. Physician order
    b. Nursing Care Plans
    c. Nursing clinical judgement
    d. As required for a particular procedure or medication

9. Patients on ECG monitoring/telemetry will have a rhythm strip printed at initiation of monitoring , every 12 hours and PRN with rhythm changes or change in patient status or at the discretion of the provider.

10. Changes in vital signs and/or PEWS scores will be communicated and documented as per the PEWS process

Documentation

Document findings on PEWS flowsheet or in electronic health record. Where narrative documentation is required use focus charting including data, action and response (DAR)
Affix ECG/telemetry strips to nurse notes/flowsheet and document interpretation including rate, rhythm, p wave, PR interval, QRS interval.

Related Documents

BC Children's Hospital CC.03.02 Assessment: Blood Pressure Measurement

BC Children's Hospital CC.03.03 Temperature Measurement

BC Children's Hospital CC.03.04 Assessment: Oximetry (SpO2) Monitoring

BC Children's Hospital CC.03.10 Pediatric Emergency Department (PED) Standards for Nursing Assessment and Documentation

BC Children's Hospital CC.03.15 Standards for Patient Assessment in the Anesthetic Care Unit (ACU) Phase I

BC Children's Hospital CC.03.20 Patient Assessment Standards PreAnesthesia and Anesthetic Care Unit (ACU) Phase II

References

BC Children's Hospital CC.03.01 (2017) Nursing Assessment of Pediatric Patients and Related Documentation, Policy and Procedure Manual. Accessed at www. http://policyandorders.cw.bc.ca

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