
**Title: WMH - Admitted Surgical Paediatric Patient
(18 months -18 years old) Clinical Procedure**



Division: Health Services

Facility or Program: Werribee Mercy Hospital

Approved by: Program Director: Surgical Services

Policy Link: [Care of the Patient Policy](#)

Purpose

The standards of care of children and adolescent in health services developed by the Royal Australian College of Physicians (2008) identify that the medical and psychosocial needs of children differ dramatically from those of adults and this should be reflected in the provision of safe and effective quality of care.

This document provides a framework of expected care. It is not designed to replace clinical judgement or medical directives.

This procedure, in conjunction with other linked procedures, is to ensure that surgical paediatric patients receive consistent safe, effective and quality health care during their admission, pre-operative and post-operative stay in the hospital by utilising the appropriate paediatric documents.

This procedure aims to provide guidance for the clinical staff in assessing, planning and providing the minimum expected standard of care for pre and post-operative paediatric patients.

This procedure is limited to the care of paediatric surgical patient pre-operatively and post-operative management at the ward or unit. Post-operative care and management of patient in PACU is under "Post Procedure Care in the Post Anaesthetic Care Unit (PACU) Procedure".

Who Must Comply

All Medical and Nursing staff.

Procedure

Pre-Operative Management

1. Admission – ensure all relevant information is current and correct (i.e.: Parent / Carer / NOK contact details). Refer to [Patient Identification Procedure](#).
2. Identify / Introduce. Refer to [Patient Identification Procedure](#)
 - 2.1 Identify the patient using at least three identifiers (Name, D.O.B., UR Number, Address)
 - 2.2 Use correct and appropriate wristband. Use "Red" wristband if patient have relevant Alerts. Refer to [Clinical Alerts and Identification Procedure](#)
 - 2.3 Introduce yourself / the medical team to the patient / parent / carer to give them time to clarify question and be given preoperative education to allay anxiety. (Bailey, 2010)
3. Conduct the pre-operative interview in a clinically appropriate environment to maintain privacy.
4. Consider the use of interpreter if applicable. Refer to "[Interpreting Services Procedure](#)" policy.
5. Check and confirm if the right consent has been signed by parent / carer. If not, inform the Theatre ANUM / Surgeon or the Anaesthetist. Refer to "[Guideline for Consent to and Refusal of Medical treatment](#)"
6. Record baseline observations (inclusive of Blood Pressure using the appropriate cuff size), assessment, medical history and other relevant information using the following forms and assessment tools: Refer to <https://www.victor.org.au/users/> for the proper use of the different ViCTOR charts. (Victorian Paediatric Clinical Network)
 - 6.1 ViCTOR chart
 - 6.1.1 [1 to 4y/o](#) VP0014
 - 6.1.2 [5 to 11y/o](#) VP0511

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- 6.1.3 [12 to 18y/o](#) VP01218)
 - 6.2 Nursing Admission Form - Day Stay (AD 1790) or Overnight Admission (AD 1791)
 - 6.2.1 Use Little Schmidy Falls Risk Assessment Tool
 - 6.2.2 Glamorgan Pressure Injury Risk Assessment Tool
 - 6.3 Preoperative checklist (AD1860)
 - 6.4 Paediatric Medication Chart, obtain "[Best Possible Medication History](#)" if possible
 - 6.5 Anaesthetic Form (AD1505)
 - 6.6 Progress notes (AD 2300)
 - 6.7 Basing on clinical assessment, use forms specific to patient's clinical state (e.g.: Neurovascular forms, Wound Chart)
 - 7. Perform other assessments, but not limited to:
 - 7.1 Check and confirm that the right body part has been marked if applicable.
 - 7.2 Ensure that the patient has fasted for the right amount of time
 - 7.3 Administer premedication (including EMLA cream) if applicable. Refer to "[Medication Administration Procedure](#)"
 - 7.4 Patient has changed into a theatre gown if applicable
 - 7.5 Preoperative blood test if applicable
 - 7.6 Inform theatre and/or receiving ward of any concern that may affect the care of the patient (e.g. Autism, Dyslexia or any paediatric patient needing special care requirements)
 - 8. Keep patients / parent / carer updated while waiting for their procedure.
 - 9. Escort and handover patient, with parent or carer if applicable, to theatre. Refer to "[Clinical Handover Procedure](#)"

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Post-Operative Management

1. Prior to the arrival of the paediatric patient at the unit / ward, the unit nurse should check and make sure that all bedside emergency equipment / devices are ready, accessible and functioning properly.
2. Take handover from PACU staff. Check that the following are noted, documented and /or checked prior to taking the patient back to the unit:
 - a. Post Op medical orders are clear and concise
 - b. Observations of the patients are within the acceptable parameters.
 - c. The last set of PACU observations should be documented by PACU staff on the appropriate ViCTOR Chart
 - d. Surgical wounds, if applicable, are dressed accordingly. Dressings should be dry, clean and intact.
 - e. Infusions are properly documented.
 - f. Post op medicines and script are done, if applicable.
 - g. Handover and other related documents are signed off by the staff handing over and staff receiving hand over.
3. Upon arrival at the **DPU**, assess, perform and document physiologic observations. Baseline post-operative observations for all paediatric surgical patients should include, but not limited to Level of Consciousness (LOC), Pulse rate, Respiratory rate, Oxygen saturation, Blood pressure and pain done at:
 - a. ½ hourly for the first 1 hour then a set of observation prior to discharge
 - b. And / or as directed by the surgeon via documented post-operative orders
 - c. And / or as clinically indicated by the patient's condition
 - d. And / or as per relevant care related to the therapy the patient is receiving
4. Upon arrival at the **Ward**, assess, perform and document physiologic observations. Baseline post-operative observations for all paediatric surgical patient should include, but not limited to LOC, Pulse rate, Respiratory rate, Oxygen saturation, Blood pressure and pain done at:
 - a. ½ hourly for the first 4 hours then;
 - b. hourly for 2 hours then
 - c. 4hourly and PRN thereafter
 - d. And / or as directed by the surgeon via documented post-operative orders
 - e. And / or as clinically indicated by the patient's condition
 - f. And / or as per relevant care related to the therapy the patient is receiving
5. All assessment and observations should be documented on the relevant forms:
 - a. ViCTOR Chart
 - i. [1 to 4y/o](#) VP0014
 - ii. [5 to 11y/o](#) VP0511
 - iii. [12 to 18y/o](#) VP01218
 - iv. [Paediatric Neurological Chart](#) VPN01
 - b. Paediatric Medication Chart
 - c. Nursing Admission- Day Stay Form (MR) / Inpatient Form
 - d. Fluid chart
 - e. Basing on clinical assessment, use forms specific to patient's clinical state (eg: Neurovascular forms, Wound Chart)
6. For inpatients, use the Paediatric Care Plan to update the patient's plan of care.

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7. A "Criteria Led Discharge" and "Discharge Checklist" should be used in conjunction with clinical judgement and medical directives to safely discharge the patient.
8. Special considerations:
 - a. Wound / wound dressings, if applicable, should be dry, clean and intact on discharge.
 - b. Social factors; examples include a child with autism who may not be well supervised post operatively. Hence, the ward needs to pre plan the patient's care. (Royal Childrens Hospital)
 - c. Use other relevant assessment tool (ex: [FLACC](#) to assess pain) in conjunction with ViCTOR Chart to get a clear understanding of the patient's clinical state.

Escalation of Care

1. Refer to "WMH - Escalation of Care Procedure for Admitted Paediatric Patients (18months – 18 years old)" for paediatric patients breaching the reportable parameters.

Continuous Observations:

1. Patients who require continuous observations should not be admitted back to the ward / DPU.
2. Should a paediatric patient's (admitted to the ward or unit) clinical state change requiring continuous monitoring, the treating medical team should endeavour to have the patient immediately transferred to the Emergency department or PACU for post op patients until such time as the patient:
 - Returns to a stable condition and no longer requires continuous monitoring or
 - The patient has been transferred to another health care facility

Management of complications

1. Refer to "WMH - Escalation of Care Procedure for Admitted Paediatric Patients (18 months – 18 years old)"
2. Refer to specific surgical procedure guideline (*to hyperlink Tonsillectomy, Adenoidectomy, Nasal cautery, Grommets etc once Procedure / Guideline available*)

Precautions & Contraindications

N/A

Definitions

Term	Definition
Paediatric patient	This procedure refers to paediatric patients as children with age range from 18 months – 18 years old
NOK	Next of Kin
PACU	Post Anaesthetic Care Unit
PONV	Post Anaesthetic Nausea / Vomiting
RPAO	Routine Post Anaesthesia Observations
LOC	Level of Consciousness
ViCTOR	Victorian Children Tool for Observation and Response

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Links to Related Documents

- [Best Possible Medication History](#)
- [Clinical Alerts and Identification Procedure](#)
- [Clinical Handover Procedure](#)
- [WMH - Escalation of Care for Admitted Paediatric Patients \(18 months – 18 years old\) Procedure](#)
- [Guideline for Consent To & Refusal of Medical Treatment](#)
- [Interpreting Services Procedure](#)
- [Medication Administration Procedure](#)
- [Patient Identification Procedure](#)
- [Post Procedure Care in the Post Anaesthetic Care Unit \(PACU\) Procedure](#)
- [WMH - ViCTOR Observation Chart Procedure for Admitted Paediatric Patients \(18 months – 18 years old\)](#)

Key Legislation, Acts, Standards & References

1. Australian Commission on Safety and Quality in Health Care. (n.d.). *National Safety and Quality Health Service Standards*. Retrieved July 27, 2016, from <http://www.safetyandquality.gov.au/our-work/patient-identification/>
2. Bailey, L. (2010). Strategies for Decreasing Patient Anxiety in Perioperative Setting. *AORN Journal*, 445.
3. Royal Childrens Hospital. (n.d.). *Observations and Continuous Observations*. Retrieved July 26, 2016, from Clinical Guidelines: http://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Observation_and_Continuous_Monitoring/
4. Victorian Paediatric Clinical Network. (n.d.). *ViCTOR Charts*. Retrieved July 26, 2016, from ViCTOR: <https://www.victor.org.au/victor-charts/>

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Keywords

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Version History & Author / Contributors

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1	07/2016	New Procedure	Paediatric Documentation Project Officer

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Appendix 1

FLACC Scale

FLACC SCALE – (Face, Legs, Activity, Cry, Consolability)

Instructions: Rate patient in each of the five measurement categories.

Add together to determine total pain score

	0	1	2
FACE	No particular expression or smile, eye contact and interest in surroundings	Occasional grimace or frown, withdrawn, disinterested, worried look to face, eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed	Frequent to constant frown, clenched jaw, quivering chin, deep furrows on forehead, eyes closed, mouth opened, deep lines around nose/lips
LEGS	Normal position or relaxed	Uneasy, restless, tense, increased tone, rigidity, intermittent flexion/extension of limbs	Kicking or legs drawn up, hypertonicity, exaggerated flexion/extension of limbs, tremors
ACTIVITY	Lying quietly, normal position, moves easily and freely	Squirming, shifting back and forth, tense, hesitant to move, guarding, pressure on body part	Arched, rigid, or jerking, fixed position, rocking, side to side head movement, rubbing of body part
CRY	No cry or moan (awake or asleep)	Moans or whimpers, occasional cries, sighs, occasional complaint	Crying steadily, screams, sobs, moans, grunts, frequent complaints
CONSOLABILITY	Calm , content, relaxed, does not require consoling	Reassured by occasional touching, hugging, or talking to, distractible	Difficult to console or comfort

The **FLACC** is a behaviour pain assessment scale for use in non-verbal patients unable to provide reports of pain.

Instructions on how to use FLACC

1. Rate patient in each of the five measurement categories
2. Add Together
3. Document total pain score and intervene accordingly.