

ME AND MY FAMILY

PERSON-CENTRED NURSING ASSESSMENT

&

PLAN OF CARE

(Children's and Young Person's Record)

Name:

Address:

Hospital No:

H & C No:

(or affix label)

Guidance for Use

A full physical, psychological, social and risk assessment must be carried out and recorded within this document as near to the time of initial admission to the clinical setting that is practical and appropriate, taking into account the dependency and safety requirements of the person being admitted.

V050617

SIGNATURE REGISTER

To be completed by all staff making an entry into this document

This section will serve as a record of your full signature and thus satisfy professional and legal requirements

Date	Full Name (BLOCK CAPITALS)	Designation (Staff Nurse, Student Nurse)	Initials	Full Signature	Status (Permanent = P Temporary = T Bank = B, Agency = A)

ADMISSION ASSESSMENT TRACKING

Registered Nurse (RN) commencing admission assessment

Indicate which pages of the Admission Assessment are outstanding at end of duty or transfer of the patient	Date	Time	Signature

Affix Addressograph

Name:

I would like to be called:

Address:

Health and Care Number:

Hospital Number:

Date of Birth:

Age:

Gender: Male Female

Telephone Number:

Person with parental responsibility/legal guardian:

Name:

Home Number:

Relationship to patient:

Mobile Number:

Accompanied by:

Name of General Practitioner (GP):

GP Telephone Number:

Address:

ADMISSION TO

Hospital:

Ward:

Date:

Time 24 Hour(hr):

Consultant:

Source of Admission:

Doctor/Nurse Practitioner informed of admission **Name** _____
Date _____ **Time** _____

REASON FOR ADMISSION

1ST RE-ADMISSION

ADMISSION TO

Hospital:

Ward:

Date:

Time 24 Hour(hr):

Consultant:

Source of Admission:

Doctor/Nurse Practitioner informed of admission **Name** _____
Date _____ **Time** _____

REASON FOR ADMISSION

2ND RE-ADMISSION					ADMISSION TO				
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Hospital:	Ward:	Date:	Time 24 Hour(hr):	Consultant:
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Source of Admission:

Doctor/Nurse Practitioner informed of admission Name _____
 Date _____ Time _____

REASON FOR ADMISSION				
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3RD RE-ADMISSION					ADMISSION TO				
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Hospital:	Ward:	Date:	Time 24 Hour(hr):	Consultant:
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Source of Admission:

Doctor/Nurse Practitioner informed of admission Name _____
 Date _____ Time _____

REASON FOR ADMISSION				
-----------------------------	--	--	--	--

1ST ADMISSION			DATE: / /
---------------------------------	--	--	------------------

Paediatric/National Early Warning Score		Signature: _____
Weight (kg) (actual)		Signature: _____
Height (cm)		Signature: _____
Other _____		Signature: _____

1ST RE-ADMISSION			DATE: / /
------------------------------------	--	--	------------------

Paediatric/National Early Warning Score		Signature: _____
Weight (kg) (actual)		Signature: _____
Height (cm)		Signature: _____
Other _____		Signature: _____

2ND RE-ADMISSION			DATE: / /
------------------------------------	--	--	------------------

Paediatric/National Early Warning Score		Signature: _____
Weight (kg) (actual)		Signature: _____
Height (cm)		Signature: _____
Other _____		Signature: _____

3RD RE-ADMISSION

DATE: / /

Paediatric/National Early Warning Score		Signature: _____
Weight (kg) (actual)		Signature: _____
Height (cm)		Signature: _____
Other _____		Signature: _____

HOSPITAL/ WARD TRANSFER

Hospital	Ward	Date	Time	Signature

PATIENT INFORMATION

Name of School/Further Education/Occupation: _____ Does the patient agree to information being shared with primary carer? Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to answer <input type="checkbox"/> Reason _____ Primary Carer advised of admission: Yes <input type="checkbox"/> No <input type="checkbox"/> Family's First Language: _____ Interpreter required: Yes <input type="checkbox"/> No <input type="checkbox"/> (includes Sign Language)	Religion/Denomination/ Belief Group: _____ Religious/Cultural practices to be observed: _____ Ethnic Group: _____ (see page 48) Would you like to see the designated hospital Chaplain during admission? Yes <input type="checkbox"/> No <input type="checkbox"/> Aids and equipment brought into hospital, such as glasses, hearing aids, feeding pump, wheelchair etc.
CHILD'S/YOUNG PERSON'S VALUABLES Has the Valuables/Property Policy been explained? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	

1ST RE-ADMISSION**CHILD'S/YOUNG PERSON'S VALUABLES**

Aids and equipment brought into hospital, such as glasses, hearing aids, feeding pump, wheelchair etc.

Has the Valuables/Property Policy been explained? Yes No N/A

2ND RE-ADMISSION**CHILD'S/YOUNG PERSON'S VALUABLES**

Aids and equipment brought into hospital, such as glasses, hearing aids, feeding pump, wheelchair etc.

Has the Valuables/Property Policy been explained? Yes No N/A

3RD RE-ADMISSION**CHILD'S/YOUNG PERSON'S VALUABLES**

Aids and equipment brought into hospital, such as glasses, hearing aids, feeding pump, wheelchair etc.

Has the Valuables/Property Policy been explained? Yes No N/A

FAMILY & SOCIAL HISTORY

Parents' Names: _____

Address if different: _____

Siblings (ages): _____

Who lives at home with this child: _____

Health Visitor: _____ Tele. No. _____

Community Children's Nurse: _____ Tele. No. _____

Social Services agencies involved: Yes No

If yes to above, give details (to include which family member/Social Worker etc):

Social Worker: _____ Tele. No. _____

Child Protection Register: Yes Past/Current. or No

If Yes: _____ Category: _____ Date Added: _____

Other Healthcare Professional (Dietician, Physiotherapist, Speech and Language Therapist, etc):

Is the child/young person a carer for another member of his/her family? Yes No

If yes, ensure referral to Gateway Services is completed.

Has Understanding the Needs of Children in Northern Ireland (UNOCINI) form been completed in line with local Trust policy within 24 hrs of referral? Yes No Complete by Social Services

PALLIATIVE/END OF LIFE CARE PLAN IN PLACE: Yes No N/A

**1ST RE-ADMISSION
FAMILY & SOCIAL HISTORY**

DATE: / /

Any changes Yes If Yes, give details No

**2ND RE-ADMISSION
FAMILY & SOCIAL HISTORY**

DATE: / /

Any changes Yes If Yes, give details No

**3RD RE-ADMISSION
FAMILY & SOCIAL HISTORY**

DATE: / /

Any changes Yes If Yes, give details No

BIRTH HISTORY: Relevant to current Admission (complete below) Not relevant to current Admission

Hospital of Birth: _____ Gestation: _____ Birth Weight: _____

Type of Delivery: _____ Neonatal Screen complete: Yes No

New born hearing assessment: Yes No If Yes give details: _____

Any problems post delivery/admission to NNU?

PAST MEDICAL HISTORY: (including asthma, hay fever, eczema, allergies, diabetes, epilepsy, cardiac, mental health issues, learning disability (NB hospital passport))

(Including past admission: any CAMHS involvement)

Immunisations up to date: Yes No If no, give details _____

FAMILY MEDICAL HISTORY: (including asthma, eczema, hay fever, allergies, diabetes, epilepsy, cardiac, mental health issues (NB 'Think child, think family'),

1ST RE-ADMISSION
**PAST MEDICAL HISTORY/
FAMILY MEDICAL HISTORY**

DATE: / /

Any updates Yes No If Yes, give details

Immunisations up to date:

Yes No If no, give details _____

2ND RE-ADMISSION
**PAST MEDICAL HISTORY/
FAMILY MEDICAL HISTORY**

DATE: / /

Any updates Yes No If Yes, give details

Immunisations up to date:

Yes No If no, give details _____

3RD RE-ADMISSION
**PAST MEDICAL HISTORY/
FAMILY MEDICAL HISTORY**

DATE: / /

Any updates Yes No If Yes, give details

Immunisations up to date:

Yes No If no, give details _____

CHILD/YOUNG PERSON'S MEDICATIONS (Where age appropriate complete this section in confidence with Child/Young Person)

SECTION A

Does the child/young person take:

- regular prescribed medication at home? Yes No
- regular over the counter medication? Yes No
- take any homeopathic medication? Yes No
- use any patches? Yes No

If yes to any of the above complete Section B.

Is the child/young person involved in any clinical trials? Yes No

Does the child/young person have any difficulty swallowing medication? Yes No

SECTION B

Medication brought to hospital

Has medication been brought to hospital? Yes (completed below) No

Medicines retained for medication reconciliation?

Yes No

Retained for use in accordance with Child/Young Persons own drugs scheme?

Yes No

Securely stored in dedicated Child/Young Persons drugs bag?

Yes N/A

Drugs stored in ward fridge as appropriate?

Yes N/A

Controlled Drugs (CD) stored in CD cupboard and entered in the appropriate register?

Yes N/A

Any additional information

1ST RE-ADMISSION

CHILD/YOUNG PERSON'S MEDICATIONS

DATE: / /

Any changes Yes No If Yes, give details

2ND RE-ADMISSION

CHILD/YOUNG PERSON'S MEDICATIONS

DATE: / /

Any changes Yes No If Yes, give details

3RD RE-ADMISSION

CHILD/YOUNG PERSON'S MEDICATIONS

DATE: / /

Any changes Yes No If Yes, give details

ALLERGIES/MEDICINES SENSITIVITIES

(This section must be completed)

Date	Medicine/Allergen	Type of Reaction (e.g. rash)

No known allergies Please tick

1ST RE-ADMISSION	No known allergies <input type="checkbox"/> Please tick DATE: / /
2ND RE-ADMISSION	No known allergies <input type="checkbox"/> Please tick DATE: / /
3RD RE-ADMISSION	No known allergies <input type="checkbox"/> Please tick DATE: / /

ALERTS

RECENT CONTACT WITH INFECTIOUS DISEASES: (Also complete page 10-13)

Diarrhoea/Vomiting: Yes <input type="checkbox"/> No <input type="checkbox"/>	Methicillin Resistant Staphylococcus Aureus (MRSA): Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Respiratory Syncytial Virus (RSV): Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Clostridium Difficile (C. Diff): Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Multi-Drug Resistant Organism(MDRO): Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Transferred from a hospital outside of NI: Yes <input type="checkbox"/> No <input type="checkbox"/>
Tracheostomy: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other Medical devices:	
Identity band/bands on patient: Yes <input type="checkbox"/> No <input type="checkbox"/> If no why not _____	

1ST RE-ADMISSION ALERTS DATE: / / Identity band/bands on patient:	Any changes Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, give details Yes <input type="checkbox"/> No <input type="checkbox"/> If no why not _____
---------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

2ND RE-ADMISSION ALERTS DATE: / / Identity band/bands on patient:	Any changes Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, give details Yes <input type="checkbox"/> No <input type="checkbox"/> If no why not _____
---------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

3RD RE-ADMISSION ALERTS DATE: / / Identity band/bands on patient:	Any changes Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, give details Yes <input type="checkbox"/> No <input type="checkbox"/> If no why not _____
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INFECTION PREVENTION CONTROL (IPC) RISK ASSESSMENT					
V180117		Admission Risk Assessment			Inpatient Review <i>Note new clinical details – Date + Sign</i>
A	Infective Diarrhoea				
1	If known, please state the normal stool habit of child/young person using Bristol Stool Chart Scale: 1 2 3 4 5 6 7	<i>Circle as appropriate</i>			
2	Is the child/young person currently having diarrhoea that may be related to an infection? If Yes , isolate until cause is known. (NB Rule out recent laxatives/enemas and underlying clinical diagnoses)	Yes	No	Unknown	
3	Has the child/young person been in a ward or nursing/residential home where others are having diarrhoea/vomiting in last 7days?	Yes	No	Unknown	
4	Has the child/young person's family had diarrhoea/vomiting in last 7 days?	Yes	No	Unknown	
5	Is viral Gastroenteritis/Norovirus suspected or confirmed?	Yes	No	Suspected/Confirmed Specimen Date <small>If known:-</small>	
6	Has the child/young person a history of <i>Clostridium difficile</i> ?	Yes	No	Specimen Date <small>If known:</small>	
B	Multidrug Resistant Organisms (MDROs) <i>(If YES to any below, follow Trust/Regional policy)</i>				
Does this child/young person have a history of any of the following:-					
7	CPE/CPO colonisation or infection? [CPE/CPO = Carbapenemase Producing Enterobacteriaceae / Organism]	Yes	No		
8	Close contact of a patient with CPE/CPO? *CPE Close Contact - person living in the same house; sharing the same sleeping space (room or hospital bay) or a sexual partner.	Yes	No		
9	Transferred from or a history of admission to a hospital outside NI in last 12 months?	Yes	No		
10	Admission to an ICU since 2010?	Yes	No		
If yes to 7-10 & admitted to hospital - isolate & screen. Refer to local CPE/CPO policy.					
11	MRSA-Methicillin Resistant Staphylococcus aureus?	Yes	No		
12	ESBL-Extended-Spectrum Beta-Lactamase producers?	Yes	No		
13	VRE/GRE-Vancomycin/ Glycopeptide Resistant Enterococci?	Yes	No		
C	Other Infection Risks				
14	Communicable diseases: - Any current symptoms or recently had contact with communicable disease? (e.g. Pertussis, Chicken Pox, Measles etc.)	Yes	No		
15	Respiratory assessment: - Respiratory symptoms indicative of TB, recent contact with TB case or with TB-high risk country; symptoms of Flu; recent travel +/- symptoms	Yes	No		
16	Skin/soft tissue: - signs/symptoms of infection (pus/redness/lesions/skin-break/rash)?	Yes	No		
If 'Yes' to 5,6 or 7,8 above - Contact IPC Team in your Trust [or PHA (Duty room) in Private-Sector]					
17	IPC Team informed?	Yes	No	N/A	Date/time:
18	PHA been informed?	Yes	No	N/A	
19	Has NIAS been informed of any infection risks?	Yes	No	N/A	
Other relevant information (e.g. antibiotic treatment/part of outbreak/MRSA management/screening etc.) Details:-					
D	Child/Young Person Placement on Admission				
If the child/young person requires isolation please note date, time & location of isolation:-					
Date:		Time:		Location:	
If not isolated within 4 hours of admission please state reason why and actions to achieve isolation:-					
E	Admission Sign-Off:-				
Hospital:		Ward/Facility:		Date/Time:-	
PRINT Admitting Nurse Name :-			Signature:-		
F	Discharge to Community Facility or Transfer to another Trust / Hospital				
Complete an up to date IPC summary prior to Discharge/transfer. Include this detail in child/young person transfer/discharge information to the receiving Hospital/Facility, (or photocopy this page if preferred)					

Signature _____ Date _____ Time _____

INFECTION PREVENTION CONTROL (IPC) RISK ASSESSMENT

V180117

Admission Risk Assessment

Inpatient Review

Note new clinical details –
Date + Sign

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3	Has this child/young person been in a ward or nursing/residential home where others are having diarrhoea/vomiting in last 7days?	Yes	No	Unknown
4	Has child/young person's family had diarrhoea/vomiting in last 7 days?	Yes	No	Unknown
5	Is viral Gastroenteritis/Norovirus suspected or confirmed?	Yes	No	Suspected/Confirmed Specimen Date If known:-
6	Has this child/young person a history of <i>Clostridium difficile</i> ?	Yes	No	Specimen Date If known:-

B		Multidrug Resistant Organisms (MDROs)		
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9	Transferred from or a history of admission to a hospital outside NI in last 12 months?	Yes	No	
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12	ESBL-Extended-Spectrum Beta-Lactamase producers?	Yes	No	
13	VRE/GRE-Vancomycin/ Glycopeptide Resistant Enterococci?	Yes	No	

C		Other Infection Risks		
14	Communicable diseases: - Any current symptoms or recently had contact with communicable disease? (e.g. Pertussis, Chicken Pox, Measles etc.)	Yes	No	
15	Respiratory assessment: - Respiratory symptoms indicative of TB, recent contact with TB case or with TB-high risk country; symptoms of Flu; recent travel +/- symptoms	Yes	No	
16	Skin/soft tissue: - signs/symptoms of infection (pus/redness/lesions/skin-break/rash)?	Yes	No	
If 'Yes' to 5,6 or 7,8 above - Contact IPC Team in your Trust [or PHA (Duty room) in Private-Sector]				
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18	PHA been informed?	Yes	No	N/A
19	Has NIAS been informed of any infection risks?	Yes	No	N/A

Other relevant information (e.g. antibiotic treatment/part of outbreak/MRSA management/screening etc.)
Details:-

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Date:	Time:	Location:		
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Hospital:	Ward/Facility:	Date/Time:-		
PRINT Admitting Nurse Name :-	Signature:-			

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6	Has this child/young person a history of <i>Clostridium difficile</i> ?	Yes	No	Specimen Date If known:-

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Signature _____ Date _____ Time _____

Guidance for Use

Please complete sections as outlined below.

- Pages 16-30 Child/young person nursing assessment to be completed within 6 hours from admission.
 - Risk assessments should all be completed within 6 hours of admission except the **STAMP** (which should be completed within 24 hrs of admission)
- Page 10-13 Infection Preventions & Control Admission Risk Assessment
- Page 19 STAMP – Screening Tool for the Assessment of Malnutrition in Paediatrics
- Page 21 Moving and Handling Risk Assessment
- Page 22 GLAMORGAN SCALE – Paediatric Pressure Ulcer Risk Assessment
- Page 27 Bed Rails Risk Assessment
- Page 31-30 Child/Young Person's Centred Care Plan - PACE
- Pages 40-47 Discharge Information checklist (to be completed on discharge)
- Page 48 Glossary of Terms, Ethnic Groups

THE CHILD'S/YOUNG PERSON'S/PARENT'S STORY – This section MUST be completed unless the child/young person/parent is unable to give the details

What matters to you and your child/young person during their stay?

How can we support you?

1ST RE-ADMISSION

DATE: / /

THE CHILD'S/YOUNG PERSON'S/PARENT'S STORY – This section MUST be completed unless the child/young person/parent is unable to give the details

What matters to you and your child/young person during their stay?

How can we support you?

2ND RE-ADMISSION

DATE: / /

THE CHILD'S/YOUNG PERSON'S/PARENT'S STORY – This section MUST be completed unless the child/young person/parent is unable to give the details

What matters to you and your child/young person during their stay?

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3RD RE-ADMISSION

DATE: / /

THE CHILD'S/YOUNG PERSON'S/PARENT'S STORY – This section MUST be completed unless the child/young person/parent is unable to give the details

What matters to you and your child/young person during their stay?

How can we support you?

NURSING ASSESSMENT

Assessment of aspects of life (Expand on any ticked boxes and link to Plan of Care)		Specific Information In this section record any additional information needed to support the development of your care plan including any detail related to readmission	
Aspects of Life	Normal/usual routine	Nursing Assessment	Assessment Need Identified
Breathing and Circulation	Difficulties identified: Yes <input type="checkbox"/> No <input type="checkbox"/> Cough present: Yes <input type="checkbox"/> No <input type="checkbox"/> Oxygen required Yes <input type="checkbox"/> No <input type="checkbox"/> Home oxygen in use Yes <input type="checkbox"/> No <input type="checkbox"/> Nebuliser Yes <input type="checkbox"/> No <input type="checkbox"/> Does the circulation appear compromised: Yes <input type="checkbox"/> No <input type="checkbox"/> Are there any vascular access devices insitu: Yes <input type="checkbox"/> No <input type="checkbox"/> Tracheostomy: Yes <input type="checkbox"/> No <input type="checkbox"/> Ventilation: Yes <input type="checkbox"/> No <input type="checkbox"/> Smoker Yes <input type="checkbox"/> No <input type="checkbox"/> Child/young person/parent: How long has the child/young person been smoking? _____ Is there anyone in the house that smokes? Yes <input type="checkbox"/> No <input type="checkbox"/>	 Trache Type: _____ Size: _____ Due changed: _____ Depth of routine suction: _____ Ventilation type: _____ If smokes, No per day:	 Smoking policy explained: Advice given re cessation:

NURSING ASSESSMENT

Assessment of aspect of life (Expand on any ticked boxes and link to Plan of Care)		Specific Information In this section record any additional information needed to support the development of your care plan including any detail related to readmission	
Aspects of Life	Normal/usual routine	Nursing Assessment	Assessment Need Identified
Communication	<p>Visual limitation Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Hearing limitation Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Hearing aid(s) Left <input type="checkbox"/> Right <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Speech limitation Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Cognitive impairment Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If there is a known history of cognitive impairment, e.g. autism or a learning disability PLEASE ensure you record clearly what communication aids are required.</p> <p>Refer to 'Hospital Passport' if available.</p>	<p>If the child/young person/parent uses sign language please record if British/Irish sign language or Makaton</p>	
Aspects of Life	Normal/usual routine	Nursing Assessment	Assessment Need Identified
Pain	<p>On admission is the child/young person in pain? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Has the child/young person had recent acute pain? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Suffer from chronic pain? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Has the child/young person taken any analgesia prior to admission (if yes what was it?) _____</p> <p>Is there anything the child/young person does at home that helps manage pain that we can provide? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Normal strategies for dealing with pain?</p>	<p>Pain Score: <u>See PEWS Chart</u></p>	

NURSING ASSESSMENT

Assessment of aspects of life (Expand on any ticked boxes and link to Plan of Care)		Specific Information In this section record any additional information needed to support the development of your care plan including any detail related to readmission	
Aspects of Life	Normal/usual routine	Nursing Assessment	Assessment Need Identified
Nutrition & Hydration	Normally nil by mouth Yes <input type="checkbox"/> No <input type="checkbox"/> Condition of mouth: _____ Appetite: _____ Usual diet: _____ Thickener Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Brand _____ Oral nutritional Supplements Yes <input type="checkbox"/> No <input type="checkbox"/> Brand/frequency: _____ Breast Feeding : Yes <input type="checkbox"/> No <input type="checkbox"/> Formula: Yes <input type="checkbox"/> No <input type="checkbox"/> Brand/amount/frequency: _____ Requires help with food Yes <input type="checkbox"/> No <input type="checkbox"/> Fluid restrictions Yes <input type="checkbox"/> No <input type="checkbox"/> Enteral feeding Yes <input type="checkbox"/> No <input type="checkbox"/> Route of feeding e.g. Nasogastric: _____	● Complete STAMP Last ate: Last drank: Food Allergies (specify): Nausea/vomiting at present: Yes <input type="checkbox"/> No <input type="checkbox"/> Any difficulty swallowing: Yes <input type="checkbox"/> No <input type="checkbox"/> If help is required please ensure child/young person is identified using your Trust process (e.g. a placemat). Enteral Device Type: _____ size: _____ cm Due changed: _____ Feed/Brand: _____ Bolus <input type="checkbox"/> Continuous <input type="checkbox"/>	Volume/rate/frequency: _____ Flushes: _____
Eliminating	Prior to admission any problems with: Bowel Yes <input type="checkbox"/> No <input type="checkbox"/> Bladder Yes <input type="checkbox"/> No <input type="checkbox"/> Nappy/toilet trained/incontinent (delete as appropriate) Requires assistance with Toileting Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Catheter Yes <input type="checkbox"/> No <input type="checkbox"/> Size: _____ Urostomy Yes <input type="checkbox"/> No <input type="checkbox"/> Bowel actions/day: (including history of constipation) _____ Type of Bowel Action: - Bristol Stool Chart _____ Stoma <input type="checkbox"/> Drains in situ <input type="checkbox"/>	Passing urine? Yes <input type="checkbox"/> No <input type="checkbox"/> Nappies wet? Yes <input type="checkbox"/> No <input type="checkbox"/> (Weigh nappies, if required) Urinalysis: Yes <input type="checkbox"/> No <input type="checkbox"/> Still to be obtained: <input type="checkbox"/> Details of any devices used including date of change required:	

STAMP SCREENING FORM – (Screening Tool for the Assessment of Malnutrition in Paediatrics)
To be completed within 24 hours of admission. To be reassessed when condition or situation changes

DATE	/ /	/ /	/ /	/ /
TIME				
WARD				

STEP 1 - DIAGNOSIS

Does the child have a diagnosis that has any nutritional implications	Score	1 st Admission	1 st Re-Admission	2 nd Re-Admission	3 rd Re-Admission
Definite nutritional implications	3				
Possible nutritional implications	2				
No nutritional implications	0				

STEP 2 – NUTRITIONAL INTAKE

What is the child’s nutritional intake?	Score	1 st Admission	1 st Re-Admission	2 nd Re-Admission	3 rd Re-Admission
No nutritional intake	3				
Recently decreased or poor nutritional intake	2				
No change in eating patterns and good nutritional intake	0				

STEP 3 – WEIGHT AND HEIGHT

Use a growth chart or the centile quick reference tables to determine the child’s measurements	Score	1 st Admission	1 st Re-Admission	2 nd Re-Admission	3 rd Re-Admission
>3 centile spaces/≥3 columns apart (or weight, 2 nd centile)	3				
>2 centile spaces /=2 columns apart	2				
0 to 1 centile spaces/columns apart	0				

STEP 4 – OVERALL RISK OF MALNUTRITION

Add up the scores from the boxes in steps 1-3 to calculate the overall risk of malnutrition	Score	1 st Admission	1 st Re-Admission	2 nd Re-Admission	3 rd Re-Admission
High Risk	≥4				
Medium Risk	2-3				
Low Risk	0-1				

Signature				
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STEP 5 – CARE PLAN

What is the child’s overall risk of malnutrition, as calculated in step 4?	Use management guidelines and/or local nutrition policies to develop a care plan for the child
High Risk	<ul style="list-style-type: none"> Take action Refer the child to a Dietician, nutritional support team or consultant Monitor as per care plan
Medium Risk	<ul style="list-style-type: none"> Monitor the child’s nutritional intake for 3 days Repeat the STAMP screening after 3 days Amend care plan as required
Low Risk	<ul style="list-style-type: none"> Continue routine clinical care Repeat the STAMP screening weekly while the child is an in-patient Amend care plan as required

NURSING ASSESSMENT

Assessment of aspects of life (Expand on any ticked boxes and link to Plan of Care)		Specific Information In this section record any additional information needed to support the development of your care plan including any detail related to readmission	
Aspects of Life	Normal/usual routine	Nursing Assessment	Assessment Need Identified
Posture & Movement	<p>Is mobility impaired? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Moving & handling:</p> <p>Aids used:</p>	<p>● Complete Moving and Handling Risk Assessment.</p>	

MOVING AND HANDLING RISK ASSESSMENT

**To be completed within 6 hours of admission
To be reassessed when condition or situation changes**

Child's/Young Person's Weight: _____ kg Actual or Approx Child's/Young Person's Height: _____ Metres

	1st Admission	1st Re-Admission	2nd Re-Admission	3rd Re-Admission
DATE	/ /	/ /	/ /	/ /
TIME				
WARD				
Is child's/young person's weight within safe working load (SWL) of equipment?	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:
Is equipment wide enough for Child/Young person's safety and comfort?	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If No, specify:
Does child/young person use a mobility aid? e.g. walking frame, wheelchair	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:
Is the mobility aid available?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> If Yes, persons own: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> If Yes, persons own: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> If Yes, persons own: Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> If Yes, persons own: Yes <input type="checkbox"/> No <input type="checkbox"/>
Are there any handling constraints? e.g. pain, external attachments, fractures, behaviour, environment, posture	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, specify:
Is child/young person independent of all moving and handling activities?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Referrals to other professionals e.g. physiotherapist, occupational therapist, ergonomics advisor	Yes <input type="checkbox"/> N/A <input type="checkbox"/> If YES, specify: Professional: _____ Date: _____ Professional: _____ Date: _____ Professional: _____ Date: _____	Yes <input type="checkbox"/> N/A <input type="checkbox"/> If YES, specify: Professional: _____ Date: _____ Professional: _____ Date: _____ Professional: _____ Date: _____	Yes <input type="checkbox"/> N/A <input type="checkbox"/> If YES, specify: Professional: _____ Date: _____ Professional: _____ Date: _____ Professional: _____ Date: _____	Yes <input type="checkbox"/> N/A <input type="checkbox"/> If YES, specify: Professional: _____ Date: _____ Professional: _____ Date: _____ Professional: _____ Date: _____
Signature				

NURSING ASSESSMENT

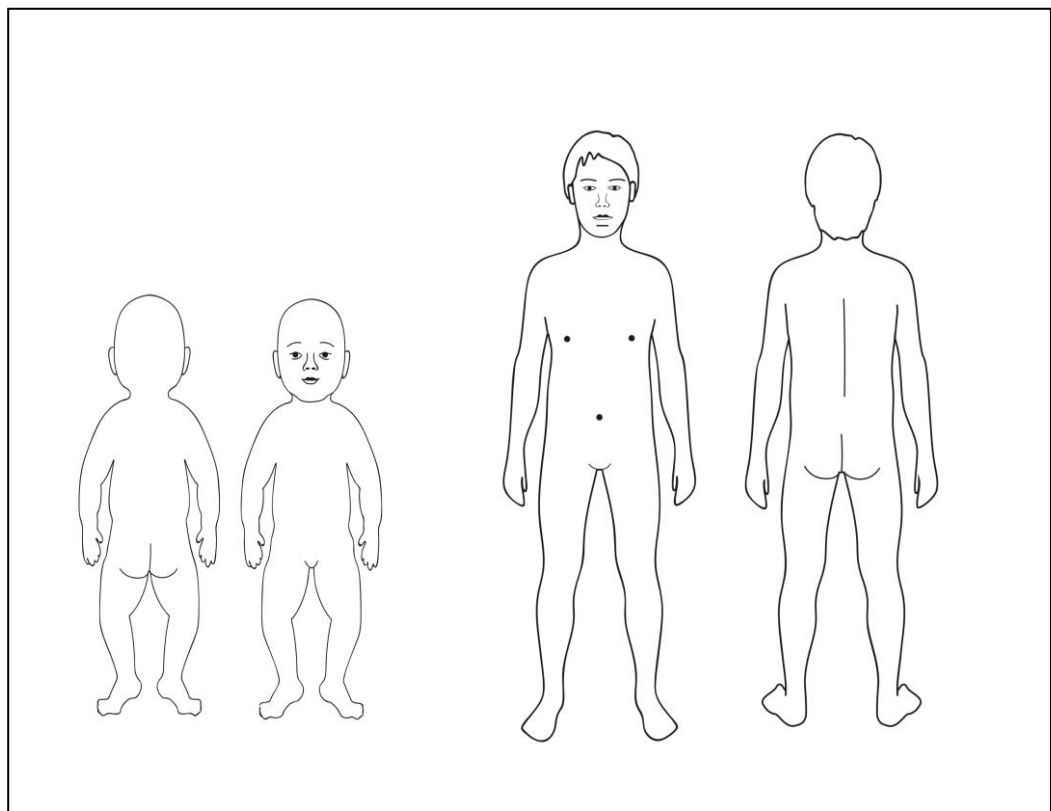
Assessment of aspect of life (Expand on any ticked boxes and link to Plan of Care)		Specific Information In this section record any additional information needed to support the development of your care plan including any detail related to readmission	
Aspects of Life	Normal/usual routine	Nursing Assessment	Assessment Need Identified
Care of Skin, Hair, Mouth & Teeth	Self-caring/Requires assistance/ Totally dependent (delete as appropriate) Skin checked? <input type="checkbox"/> Unable to check <input type="checkbox"/> Pressure ulcer Yes <input type="checkbox"/> No <input type="checkbox"/> *Other tissue damage/marks/bruising/skin conditions or any other wounds present on admission Yes <input type="checkbox"/> No <input type="checkbox"/> Loose teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>	● Complete Glamorgan Reason: _____ *Mark on body table/map. Wound assessment chart Commenced Yes <input type="checkbox"/> Not required <input type="checkbox"/>	

The Glamorgan Scale (2012) Paediatric Pressure Ulcer Risk Assessment					
To be completed within 6 hours of admission. To be reassessed when condition or situation changes.					
DATE		/ /	/ /	/ /	/ /
TIME					
WARD					
RISK FACTORS	Score	1 st Admission	1 st Re-Admission	2 nd Re-Admission	3 rd Re-Admission
MOBILITY Child cannot be moved without great difficulty or deterioration in condition / general anaesthetic	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 <90g/L)	If result is not available, write not known and score 0	1			
Low serum albumin (< 35g/L)		1			
Persistent pyrexia - temp > 38°C >4 hours	1				
Poor peripheral perfusion - cold extremities/ capillary refill > 2 seconds / cool mottled skin	1				
Inadequate nutrition - discuss with dietician if in doubt	1				
Weight less than 10 th centile	1				
Incontinence - inappropriate for age	1				
Total score for mobility section	M				
DEVICES equipment /objects /hard surface pressing or rubbing on skin	10 D				
Total score for both sections	M+D				
If the score is 10 or more then child is 'AT RISK' of pressure damage					
ACTION TAKEN? Yes or No - document in nursing record					
Signature					

Body Table and Map

Document pressure damage/ tissue damage/marks/bruising/skin conditions or any other wounds in the table below.

Body site number	Date	Time	Type of tissue damage and reason/duration if known	Signature



FOR PRESSURE DAMAGE

GRADES	
BE	Blanching erythema
G1	Grade 1 pressure damage <i>Non blanching erythema of intact skin</i>
G2	Grade 2 pressure damage <i>partial thickness skin loss with exposed dermis</i>
G3	Grade 3 pressure damage <i>Full thickness skin loss</i>
G4	Grade 4 pressure damage <i>Full thickness skin & tissue loss</i>
DTI	Deep tissue injury <i>Persistent non-blanchable deep red, maroon or purple discoloration</i>
UN	Ungradable <i>Obscured Full thickness skin & tissue loss</i>

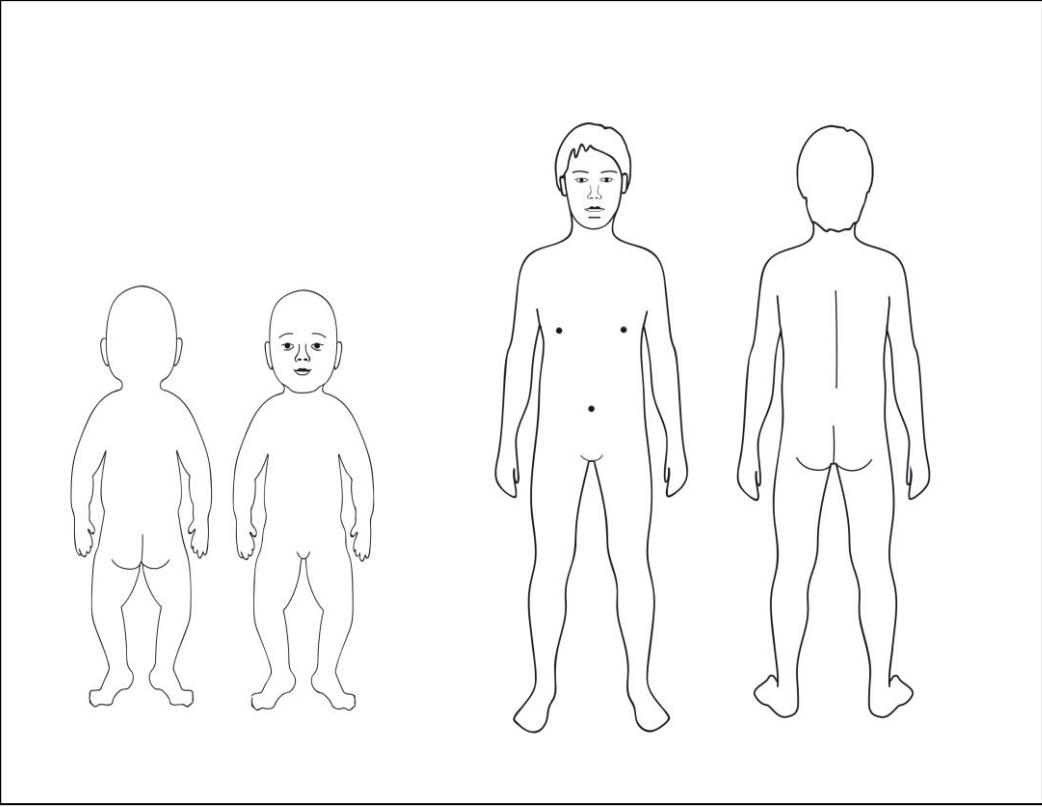
Number, code (if pressure damage) and date pressure injury/other tissue damage/marks/bruising/skin conditions or any other wounds present on admission ON BODY MAP.

Body Table and Map

Document pressure damage/ tissue damage/marks/bruising/skin conditions or any other wounds in the table below.

Body site number	Date	Time	Type of tissue damage and reason/duration if known	Signature

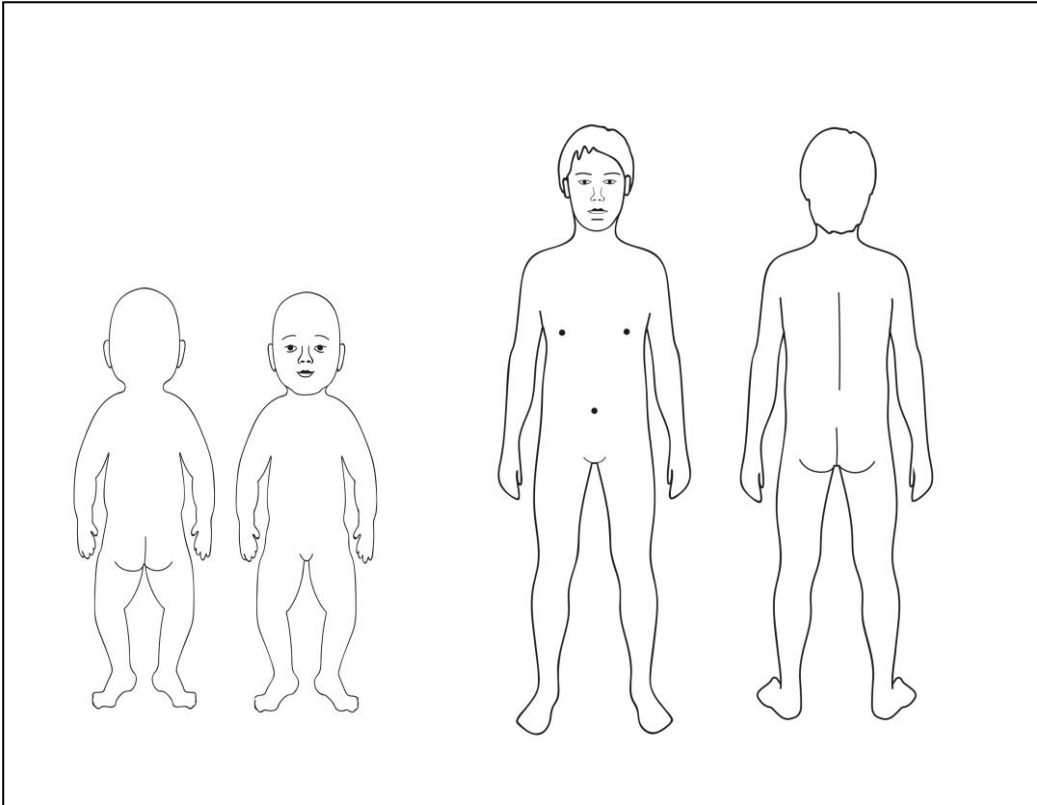
1ST RE-ADMISSION **Body Map** DATE: / /



FOR PRESSURE DAMAGE

GRADES	
BE	Blanching erythema
G1	Grade 1 pressure damage <i>Non blanching erythema of intact skin</i>
G2	Grade 2 pressure damage <i>partial thickness skin loss with exposed dermis</i>
G3	Grade 3 pressure damage <i>Full thickness skin loss</i>
G4	Grade 4 pressure damage <i>Full thickness skin & tissue loss</i>
DTI	Deep tissue injury <i>Persistent non-blanchable deep red, maroon or purple discoloration</i>
UN	Ungradable <i>Obscured Full thickness skin & tissue loss</i>

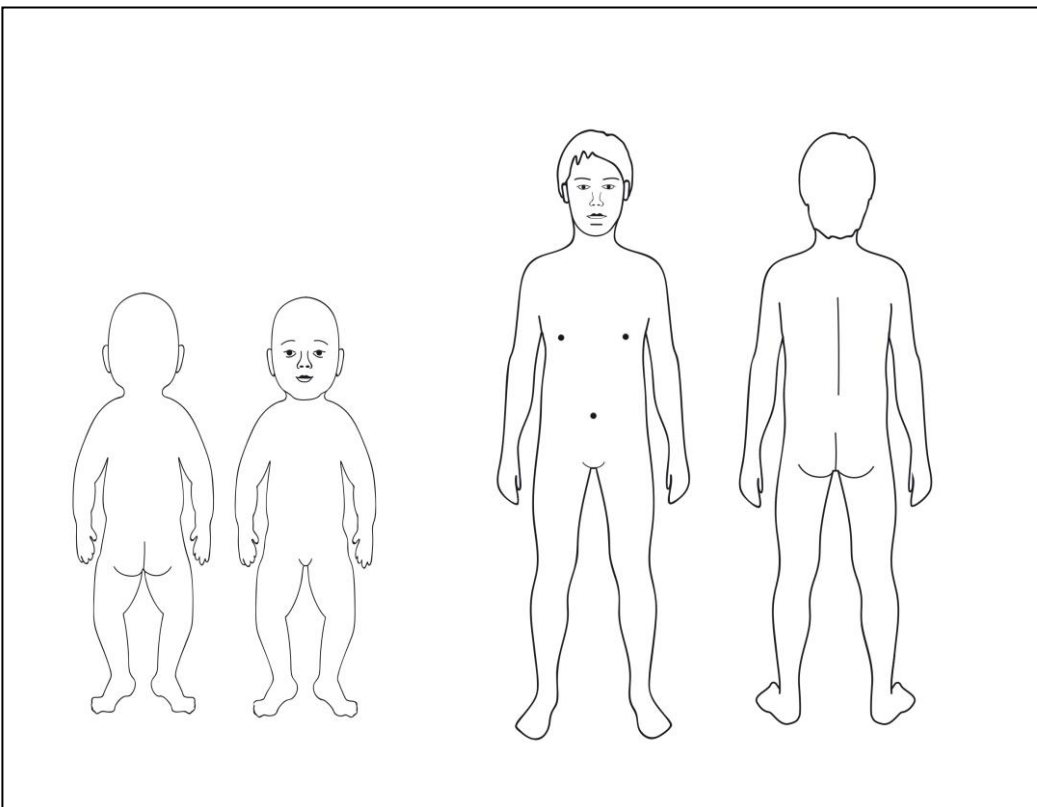
Number, code (if pressure damage) and date pressure damage/other tissue damage/marks/bruising/skin conditions or any other wounds present on admission ON BODY MAP.



FOR PRESSURE DAMAGE

GRADES	
BE	Blanching erythema
G1	Grade 1 pressure damage <i>Non blanching erythema of intact skin</i>
G2	Grade 2 pressure damage <i>partial thickness skin loss with exposed dermis</i>
G3	Grade 3 pressure damage <i>Full thickness skin loss</i>
G4	Grade 4 pressure damage <i>Full thickness skin & tissue loss</i>
DTI	Deep tissue injury <i>Persistent non-blanchable deep red, maroon or purple discolouration</i>
UN	Ungradable <i>Obscured Full thickness skin & tissue loss</i>

Number, code (if pressure damage) and date pressure damage/other tissue damage/marks/bruising/skin conditions or any other wounds present on admission ON BODY MAP.



FOR PRESSURE DAMAGE

GRADES	
BE	Blanching erythema
G1	Grade 1 pressure damage <i>Non blanching erythema of intact skin</i>
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G4	Grade 4 pressure damage <i>Full thickness skin & tissue loss</i>
DTI	Deep tissue injury <i>Persistent non-blanchable deep red, maroon or purple discolouration</i>
UN	Ungradable <i>Obscured Full thickness skin & tissue loss</i>

Number, code (if pressure damage) and date pressure damage/other tissue damage/marks/bruising/skin conditions or any other wounds present on admission ON BODY MAP.

NURSING ASSESSMENT

Assessment of aspects of life (Expand on any ticked boxes and link to Plan of Care)		Specific Information In this section record any additional information needed to support the development of your care plan including any detail related to readmission	
Aspects of Life	Normal/usual routine	Nursing Assessment	Assessment Need Identified
Rest & Sleep	Cot/Bed (delete as appropriate) Bed sharing advice provided Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Comforter used Yes <input type="checkbox"/> No <input type="checkbox"/> Parent staying if admitted? Yes <input type="checkbox"/> No <input type="checkbox"/>	● Complete bed rails risk assessment.	
Play & Education	Learning disabilities Refer to Hospital Passport Hobbies/interest:		
Expressing Sexuality/ Development	Date of Last Menstrual Period: _____ (Pregnancy test done if applicable)		
Safety Awareness <small>(Where age appropriate complete this section in confidence with Child/Young Person)</small>	Are you aware of any lifestyle choices that currently impact the child's/young person's health and wellbeing?		

Source of Information (Child/Parent/Carer/Interpreter/Other) _____

Child's/Young Person's care needs discussed with parent and/or family/carers if applicable. Yes No

Signature of child/young person _____

Signature of parent/legal guardian _____

Signature of admitting Registered Nurse _____ Date _____ Time _____

Signature of admitting Nursing Student _____ Date _____ Time _____

Countersigned by Registered Nurse _____ Date _____ Time _____

BED RAILS RISK ASSESSMENT

To be completed within 6 hours of admission

- Bed rails should be used when transporting children/young people in a bed or trolley, when the child/young person is recovering from anaesthesia/sedation and/or when he/she is unconscious. In these circumstances a Bed Rails Assessment is NOT required.
- In all other circumstances when the use of bed rails is being considered the risk matrix below should be used in conjunction with the nurses' professional judgement.

Circle the relevant criteria in considering the need for use of bed rails

		MOBILITY		
		Child/Young Person is very immobile (bedfast-or-hoist dependent)	Child/Young Person requires assistance to mobilise	Child/Young Person can mobilise without help from staff
MENTAL STATE	Child/Young Person is confused and disorientated	Use bed rails with care	Bedrails not recommended	Bedrails not recommended
	Child/Young Person is drowsy	Bedrails recommended	Use bedrails with care	Bedrails not recommended
	Child/Young Person is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails not recommended
	Child/Young Person is unconscious	Bedrails recommended	N/A	N/A

The risk matrix should be used in conjunction with the nurses' professional judgement. Remember that:-

- Child/young person with capacity can make their own decisions about bedrail use
- Child/young person with a visual impairment may be more vulnerable to falling from bed
- Child/young person with involuntary movements (e.g., spasms) may be more vulnerable to falling from bed. If bed rails recommended consider need for padded covers

National Patient Safety Agency's Safer Practice Notice 'Using bedrails safely and effectively' NPSA/2007/17

DATE	TIME	BED RAILS RECOMMENDED? YES/NO/WITH CARE	COMMENTS	DISCUSSION WITH PARENT /LEGAL GUARDIAN	SIGNATURE
1st ADMISSION					
1ST RE-ADMISSION					
2ND RE-ADMISSION					
3RD RE-ADMISSION					

Aspects of Life	Revised Nursing Assessment	Assessment Needs Identified
Breathing & Circulation		
Communication		
Pain		
Nutrition & Hydration	● Complete STAMP (Page19)	
Eliminating		
Posture & Movement	● Complete Moving and Handling Risk Assessment. (Page 21)	
Care of Skin, Hair, Mouth & Teeth	● Complete Glamorgan (Page 22) Body table/map (Page 24)	
Rest & Sleep	● Complete bed rails risk assessment. (Page 27)	
Play & Education		
Expressing Sexuality/ Development		
Safety Awareness		

Source of Information (Child/Parent/Carer/Interpreter/Other) _____

Child's/Young Person's care needs discussed with parent and/or family/carers if applicable. Yes No

Signature of child/young person _____

Signature of parent/legal guardian _____

Signature of admitting Registered Nurse _____ Date _____ Time _____

Signature of admitting Nursing Student _____ Date _____ Time _____

Countersigned by Registered Nurse _____ Date _____ Time _____

Aspects of Life	Revised Nursing Assessment	Assessment Needs Identified
Breathing & Circulation		
Communication		
Pain		
Nutrition & Hydration	● Complete STAMP (Page19)	
Eliminating		
Posture & Movement	● Complete Moving and Handling Risk Assessment. (Page 21)	
Care of Skin, Hair, Mouth & Teeth	● Complete Glamorgan (Page 22) Body table/map (Page 25)	
Rest & Sleep	● Complete bed rails risk assessment. (Page 27)	
Play & Education		
Expressing Sexuality/ Development		
Safety Awareness		

Source of Information (Child/Parent/Carer/Interpreter/Other) _____

Child's/Young Person's care needs discussed with parent and/or family/carer

if applicable. Yes No

Signature of child/young person _____

Signature of parent/legal guardian _____

Signature of admitting Registered Nurse _____ Date _____ Time _____

Signature of admitting Nursing Student _____ Date _____ Time _____

Countersigned by Registered Nurse _____ Date _____ Time _____

Aspects of Life	Revised Nursing Assessment	Assessment Needs Identified
Breathing & Circulation		
Communication		
Pain		
Nutrition & Hydration	● Complete STAMP (Page19)	
Eliminating		
Posture & Movement	● Complete Moving and Handling Risk Assessment. (Page 21)	
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Rest & Sleep	● Complete bed rails risk assessment. (Page 27)	
Play & Education		
Expressing Sexuality/ Development		
Safety Awareness		

Source of Information (Child/Parent/Carer/Interpreter/Other) _____

Child's/Young Person's care needs discussed with parent and/or family/carers if applicable. Yes No

Signature of child/young person _____

Signature of parent/legal guardian _____

Signature of admitting Registered Nurse _____ Date _____ Time _____

Signature of admitting Nursing Student _____ Date _____ Time _____

Countersigned by Registered Nurse _____ Date _____ Time _____

Person	Assessment	Plan of Care	Evaluation
What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i>	Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i>	Plan Care/Treatment/Support based on the identified needs from P and A with the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i>	Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i>

Review –Informs the next shift/handover. Summary of the shift, highlighting what has yet to be achieved.

RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

Person	Assessment	Plan of Care	Evaluation
<p>What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i></p>	<p>Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i></p>	<p>Plan Care/Treatment/Support based on the identified needs from P and A with the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i></p>	<p>Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i></p>

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RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

Person	Assessment	Plan of Care	Evaluation
<p>What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i></p>	<p>Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i></p>	<p>Plan Care/Treatment/Support based on the identified needs from P and A with the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i></p>	<p>Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i></p>

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RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

Person	Assessment	Plan of Care	Evaluation
<p>What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i></p>	<p>Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i></p>	<p>Plan Care/Treatment/Support based on the identified needs from P and A with the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i></p>	<p>Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i></p>

Review –Informs the next shift/handover. Summary of the shift, highlighting what has yet to be achieved.

RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

Person	Assessment	Plan of Care	Evaluation
What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i>	Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i>	Plan Care/Treatment/Support based on the identified needs from P and A <i>with</i> the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i>	Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i>

Review –Informs the next shift/handover. Summary of the shift, highlighting what has yet to be achieved.

RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

Person	Assessment	Plan of Care	Evaluation
What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i>	Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i>	Plan Care/Treatment/Support based on the identified needs from P and A with the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i>	Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i>

Review –Informs the next shift/handover. Summary of the shift, highlighting what has yet to be achieved.

RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

Person	Assessment	Plan of Care	Evaluation
What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i>	Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i>	Plan Care/Treatment/Support based on the identified needs from P and A with the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i>	Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i>

Review –Informs the next shift/handover. Summary of the shift, highlighting what has yet to be achieved.

RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

Person	Assessment	Plan of Care	Evaluation
What matters to the child/young person/carer? <i>Communicating with the child/young person and family to identify their needs</i>	Using nursing assessment skills to identify the needs of the child/young person <i>Collecting ongoing information/ clinical observation Building a picture</i>	Plan Care/Treatment/Support based on the identified needs from P and A with the child/young person/carer <i>Specify outcomes Obtain consent for the plan</i>	Look at the effectiveness of the plan <i>How does the child/young person/carer feel What is the progress towards attaining outcomes/meeting needs</i>

Review –Informs the next shift/handover. Summary of the shift, highlighting what has yet to be achieved.

RECORD OF NURSING CARE & OUTCOMES OF CARE

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Review –Informs the next shift/handover. Summary of the shift, highlighting what has yet to be achieved.

RECORD OF NURSING CARE & OUTCOMES OF CARE

Date	Time		Signature & designation

DISCHARGE INFORMATION/CHECKLIST

Electronic discharge complete: Yes Date: _____ Time: _____ Signature: _____

No continue and complete

The Child/Young Person is being discharged to:

Their own Home A relative's/carer's home Respite Care Hospice Under care of Social Services

Reason for admission _____

DISCHARGE CONTACTS

SAFEGUARDING

Issues identified Yes Complete below both Section A and B

No Complete Section B

SECTION A

Professional contacted	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
Health Visitor verbally informed				
Social Worker liaison				
UNOCINI generated and forwarded				
Safeguarding Children's Nurse Specialist informed				
Safeguarding checklist completed	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			
Safeguarding discharge meeting convened	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			

SECTION B

Professional contacted	N/A	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
G.P.					
Community Children's Nursing					
Social Worker					
Health Visitor/ School Nurse					
Treatment Room					
Midwife					
Other - Specify					

MEDICATION

Discharge medication checked and given: Yes None required

Anticoagulant prescription: Yes No N/A

Child's/Young Person's own medications checked and returned: Yes None to return

Child/Young Person/Parent/Primary Carer has been advised about medication: Yes No N/A

Advised by: Nurse Doctor Name _____

Home oxygen order form completed: Yes N/A

Medical certificate (16 OR OVER) required: Yes No N/A

Issued: Yes No

DRESSINGS

On discharge does the Child/Young Person have wound? Yes No If yes, has the following been done?

Treatment room Nurse/CCN letter given: Yes No N/A

3-day supply of all dressings provided: Yes No

FOLLOW UP

Follow up required: Yes No If yes, When? _____ With Whom? _____

Outpatient/Clinic appointment booked: Yes No N/A

Parent/Primary Carer informed of follow up arrangements: Yes No N/A

Letters given to Parent/Primary Carer: GP letter N/A Other: _____

DISCHARGE ADVICE LEAFLETS

Discharge advice/leaflets/teaching provided: _____

CHECK ACTIVITIES PRIOR TO DISCHARGE

IV access device/s removed: Yes No N/A

Arm band(s) removed: Yes No

If not removed please state why: _____

Property returned: Yes N/A

TRANSPORT

Transport used on leaving ward:

Left with Parent/Primary carer Yes No

If no, please specify other transport and with whom: _____

Nurse Signature: _____ Date: _____

1ST RE-ADMISSION**DISCHARGE INFORMATION/CHECKLIST**

Electronic discharge complete: Yes Date: _____ Time: _____ Signature: _____
 No continue and complete

The Child/Young Person is being discharged to:

Their own Home A relative's/carer's home Respite Care Hospice Under care of Social Services

Reason for admission _____

DISCHARGE CONTACTS**SAFEGUARDING**

Issues identified Yes Complete below both Section A and B
 No Complete Section B

SECTION A

Professional contacted	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
Health Visitor verbally informed				
Social Worker liaison				
UNOCINI generated and forwarded				
Safeguarding Children's Nurse Specialist informed				
Safeguarding checklist completed	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			
Safeguarding discharge meeting convened	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			

SECTION B

Professional contacted	N/A	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
G.P.					
Community Children's Nursing					
Social Worker					
Health Visitor/ School Nurse					
Treatment Room					
Midwife					
Other - Specify					

1ST RE-ADMISSION**MEDICATION**Discharge medication checked and given: Yes None required Anticoagulant prescription: Yes No N/A Child's/Young Person's own medications checked and returned: Yes None to return Child/Young Person/Parent/Primary Carer has been advised about medication: Yes No N/A Advised by: Nurse Doctor Name _____Home oxygen order form completed: Yes N/A Medical certificate (16 OR OVER) required: Yes No N/A Issued: Yes No **DRESSINGS**On discharge does the Child/Young Person have wound? Yes No If yes, has the following been done?Treatment room Nurse/CCN letter given: Yes No N/A 3-day supply of all dressings provided: Yes No **FOLLOW UP**Follow up required: Yes No If yes, When? _____ With Whom? _____Outpatient/Clinic appointment booked: Yes No N/A Parent/Primary Carer informed of follow up arrangements: Yes No N/A Letters given to Parent/Primary Carer: GP letter N/A Other: _____**DISCHARGE ADVICE LEAFLETS**Discharge advice/leaflets/teaching provided: _____
_____**CHECK ACTIVITIES PRIOR TO DISCHARGE**IV access device/s removed: Yes No N/A Arm band(s) removed: Yes No

If not removed please state why: _____

Property returned: Yes N/A **TRANSPORT**

Transport used on leaving ward:

Left with Parent/Primary carer Yes No

If no, please specify other transport and with whom: _____

Nurse Signature: _____ Date: _____

Electronic discharge complete: Yes Date: _____ Time: _____ Signature: _____
 No continue and complete

The Child/Young Person is being discharged to:

Their own Home A relative's/carer's home Respite Care Hospice Under care of Social Services

Reason for admission _____

DISCHARGE CONTACTS

SAFEGUARDING

Issues identified Yes Complete below both Section A and B
 No Complete Section B

SECTION A

Professional contacted	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
Health Visitor verbally informed				
Social Worker liaison				
UNOCINI generated and forwarded				
Safeguarding Children's Nurse Specialist informed				
Safeguarding checklist completed	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			
Safeguarding discharge meeting convened	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			

SECTION B

Professional contacted	N/A	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
G.P.					
Community Children's Nursing					
Social Worker					
Health Visitor/ School Nurse					
Treatment Room					
Midwife					
Other - Specify					

2ND RE-ADMISSION**MEDICATION**Discharge medication checked and given: Yes None required Anticoagulant prescription: Yes No N/A Child's/Young Person's own medications checked and returned: Yes None to return Child/Young Person/Parent/Primary Carer has been advised about medication: Yes No N/A Advised by: Nurse Doctor Name _____Home oxygen order form completed: Yes N/A Medical certificate (16 OR OVER) required: Yes No N/A Issued: Yes No **DRESSINGS**On discharge does the Child/Young Person have wound? Yes No If yes, has the following been done?Treatment room Nurse/CCN letter given: Yes No N/A 3-day supply of all dressings provided: Yes No **FOLLOW UP**Follow up required: Yes No If yes, When? _____ With Whom? _____Outpatient/Clinic appointment booked: Yes No N/A Parent/Primary Carer informed of follow up arrangements: Yes No N/A Letters given to Parent/Primary Carer: GP letter N/A Other: _____**DISCHARGE ADVICE LEAFLETS**

Discharge advice/leaflets/teaching provided: _____

CHECK ACTIVITIES PRIOR TO DISCHARGEIV access device/s removed: Yes No N/A Arm band(s) removed: Yes No

If not removed please state why: _____

Property returned: Yes N/A **TRANSPORT**

Transport used on leaving ward:

Left with Parent/Primary carer Yes No

If no, please specify other transport and with whom: _____

Nurse Signature: _____ Date: _____

Electronic discharge complete: Yes Date: _____ Time: _____ Signature: _____
 No continue and complete

The Child/Young Person is being discharged to:

Their own Home A relative's/carer's home Respite Care Hospice Under care of Social Services

Reason for admission _____

DISCHARGE CONTACTS

SAFEGUARDING

Issues identified Yes Complete below both Section A and B
 No Complete Section B

SECTION A

Professional contacted	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
Health Visitor verbally informed				
Social Worker liaison				
UNOCINI generated and forwarded				
Safeguarding Children's Nurse Specialist informed				
Safeguarding checklist completed	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			
Safeguarding discharge meeting convened	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason: _____			

SECTION B

Professional contacted	N/A	Reason for Referral	Name of Person contacted	Date contacted	Name of Referrer
G.P.					
Community Children's Nursing					
Social Worker					
Health Visitor/ School Nurse					
Treatment Room					
Midwife					
Other - Specify					

3RD RE-ADMISSION**MEDICATION**Discharge medication checked and given: Yes None required Anticoagulant prescription: Yes No N/A Child's/Young Person's own medications checked and returned: Yes None to return Child/Young Person/Parent/Primary Carer has been advised about medication: Yes No N/A Advised by: Nurse Doctor Name _____Home oxygen order form completed: Yes N/A Medical certificate (16 OR OVER) required: Yes No N/A Issued: Yes No **DRESSINGS**On discharge does the Child/Young Person have wound? Yes No If yes, has the following been done?Treatment room Nurse/CCN letter given: Yes No N/A 3-day supply of all dressings provided: Yes No **FOLLOW UP**Follow up required: Yes No If yes, When? _____ With Whom? _____Outpatient/Clinic appointment booked: Yes No N/A Parent/Primary Carer informed of follow up arrangements: Yes No N/A Letters given to Parent/Primary Carer: GP letter N/A Other: _____**DISCHARGE ADVICE LEAFLETS**Discharge advice/leaflets/teaching provided: _____
_____**CHECK ACTIVITIES PRIOR TO DISCHARGE**IV access device/s removed: Yes No N/A Arm band(s) removed: Yes No

If not removed please state why: _____

Property returned: Yes N/A **TRANSPORT**

Transport used on leaving ward:

Left with Parent/Primary carer Yes No

If no, please specify other transport and with whom: _____

Nurse Signature: _____ Date: _____

GLOSSARY OF TERMS

BA	Bowel Action
C. Diff	Clostridium Difficile
CAMHS	Child & Adolescent Mental Health Service
CCN	Community Children’s Nurse
CPE	Carbapenemase Producing Enterobacteriaceae
CPO	Carbapenemase Producing Organisms
DOB	Date of Birth
ED	Emergency Department
ESBL	Extended-Spectrum Beta-Lactamase Producers
H&C	Health & Care
HCP	Healthcare Professional
ID	Identification
IPC	Infection Prevention Control
MDRO	Multi-Drug Resistant Organism
MRSA	Methicillin Resistant Staphylococcus Aureus
MSSA	Methicillin Sensitive Staphylococcus Aureus
N/A	Not Applicable
NEWS	National Early Warning Score
NIAS	Northern Ireland Ambulance Service
NNU	Neonatal Unit
NPUAP	National Ulcer Pressure Ulcer Advisory Panel
PVL-SA	Panton-Valentine Leukocidin <i>Staphylococcus Aureus</i>
PEG	Percutaneous Endoscopic Gastrostomy
PEWS	Paediatric Early Warning Score
PHA	Public Health Agency
RSV	Respiratory Syncytial Virus
UNOCINI	Understanding the Needs of Children in Northern Ireland
SCNS	Safeguarding Children Nurse Specialist
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
TB	Tuberculosis
VRE/GRE	Vancomycin/Glycopeptide Resistant Enterococci

ETHNIC GROUPS		
Bangladeshi	Chinese	Pakistani
Black African	Indian	White
Black Caribbean	Irish Traveller	Filipino
Black other	Mixed Ethnic	