ME AND MY FAMILY

PERSON-CENTRED NURSING ASSESSMENT & PLAN OF CARE

(Children's and Young Person's Record)

Name:

Address:

DOB:

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.

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				

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 ☐ No ☐ Unable to answer ☐
Reason_____

Primary Carer advised of admission: Yes ☐ No ☐

Family's First Language: _____

Interpreter required: Yes ☐ No ☐
(*includes Sign Language*)

Religion/Denomination/ Belief Group: _____

Religious/Cultural practices to be observed:
_____

Ethnic Group: _____
(see page 24)

Would you like to see the designated hospital Chaplain during admission? Yes ☐ No ☐

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 ☐ 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 ☐

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'),

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

ALLERGIES/MEDICINES SENSITIVITIES

(This section must be completed)

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

No known allergies ☐ Please tick

ALERTS

RECENT CONTACT WITH INFECTIOUS DISEASES: **(Also complete page 6)**

Diarrhoea/Vomiting: Yes ☐ No ☐

Methicillin Resistant Staphylococcus Aureus (MRSA): Yes ☐ No ☐ Unknown ☐

Respiratory Syncytial Virus (RSV): Yes ☐ No ☐ Unknown ☐

Clostridium Difficile (C. Diff): Yes ☐ No ☐ Unknown ☐

Multi-Drug Resistant Organism(MDRO): Yes ☐ No ☐ Unknown ☐

Transferred from a hospital outside of NI: Yes ☐ No ☐

Tracheostomy: Yes ☐ No ☐

Other Medical devices:

Identity band/bands on patient: Yes ☐ No ☐ **If no why not** _____

INFECTION PREVENTION & CONTROL ADMISSION RISK ASSESSMENT
(To be completed by the Registered Nurse on patient's admission)

RISK ASSESSMENT FOR INFECTIVE DIARRHOEA

If known, please state the normal stool habit of the patient/client using the Bristol Stool Form Scale: ☐

Is this child/young person currently having diarrhoea where infection is the suspected cause? Yes ☐ No ☐
(NB Rule out recent laxatives/enemas and underlying clinical diagnoses)

Has this child/young person been in a ward or home where other patients have diarrhoea and/or vomiting? Yes ☐ No ☐ Unknown ☐

Has this child/young person's family had diarrhoea and/or vomiting? Yes ☐ No ☐ Unknown ☐

Is viral Gastroenteritis/Norovirus suspected or confirmed? Yes ☐ No ☐ Suspected ☐ Confirmed ☐

Has this child/young person a history of *Clostridium difficile* (Colonisation or Infection)?
Yes ☐ No ☐ Date of Specimen ☐

Multidrug Resistant Organisms (MDROs)

Does this child/young person have a history of any of the following:
CPE = Carbapenemase Producing Enterobacteriaceae/CPO = *Carbapenemase Producing Organism*

- CPE/CPO colonisation or infection
- Close contact of a patient with CPE/CPO
- Transferred from or a history of admission to a hospital outside NI. Yes ☐ No ☐
- Admission to an Intensive Care Unit (ICU) in the last 12 months. If yes and admitted to an acute hospital, screen on admission for CPE/CPO/MDROs Details:
  (if yes, isolate & screen patients on admission. Refer to local CPI/CPO management guidance)

MRSA = Methicillin Resistant *Staphylococcus aureus* - Yes ☐ No ☐ Details: _____

ESBL = Extended-Spectrum Beta-Lactamase producers - Yes ☐ No ☐ Details: _____

VRE/GRE = Vancomycin/Glycopeptide Resistant Enterococci - Yes ☐ No ☐ Details: _____

Has the child/young person ever been admitted to an ICU? Yes ☐ No ☐ Details: _____

If "Yes" to any of the above, contact Infection Prevention and Control (IPC) Team at receiving hospital.

Date: _____

Communicable diseases: - Any current symptoms or recently had contact with a communicable disease? (e.g. Pertussis, Chicken Pox etc) Yes ☐ No ☐ Specify (with dates): _____

Respiratory assessment: - Respiratory symptoms which indicate need for IPC precautions (e.g. Respiratory Syncytial Virus, symptoms or investigation for Tuberculosis (TB) recent travel +/- symptoms to indicate novel virus*, any MDROs (as above) in sputum culture etc.) Yes ☐ No ☐ Specify (with dates): _____

Skin/soft tissue: - any signs/symptoms of infection (pus/redness etc. At lesion/skin break) or rash?) Yes ☐ No ☐
Details: _____

Infection Prevention and Control Nurse been informed? Yes ☐ No ☐ Date: _____ Time: _____

Has Northern Ireland Ambulance Service been informed of any infection risks? Yes ☐ No ☐ N/A ☐
Date: _____ _____Time: _____

Name of nurse completing admission risk assessment: _____ Date: _____

Name of nurse completing discharge/transfer risk assessment: _____ Date: _____

Record relevant information e.g. antibiotic treatment/part of outbreak/MRSA management/screening results & if further screens required. SPECIFICALLY NOTE IF THE PATIENT HAS BEEN ADMITTED TO AN INTENSIVE CARE UNIT IN THE LAST 12 MONTHS.

Receiving Unit to complete: Patient/Client Placement

Does this patient/client require a single room? Yes ☐ No ☐

If not isolated on/within 4 hours of admission please state reason why? _____

What actions will be taken to achieve isolation? _____

*Novel virus – virus not seen before

Guidance for Use

Please complete sections as outlined below.

- Pages 8-16 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 6 Infection Preventions & Control Admission Risk Assessment
- Page 11 STAMP – Screening Tool for the Assessment of Malnutrition in Paediatrics
- Page 13 Moving and Handling Risk Assessment
- Page 14 GLAMORGAN SCALE – Paediatric Pressure Ulcer Risk Assessment
- Page 17 Bed Rails Risk Assessment
- Page 18 Child/Young Person's Centred Care Plan
- Pages 22-23 Discharge Information checklist (to be completed on discharge)
- Page 24 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?

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 ☐ No ☐ Cough present: Yes ☐ No ☐ Oxygen required Yes ☐ No ☐ Home oxygen in use Yes ☐ No ☐ Nebuliser Yes ☐ No ☐ Does the circulation appear compromised: Yes ☐ No ☐ Are there any vascular access devices insitu: Yes ☐ No ☐ Tracheostomy: Yes ☐ No ☐ Ventilation: Yes ☐ No ☐ Smoker Yes ☐ No ☐ Child/young person/parent: How long has the child/young person been smoking? _____ Is there anyone in the house that smokes? Yes ☐ No ☐	**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	**Visual limitation** Yes ☐ No ☐ **Hearing limitation** Yes ☐ No ☐ **Hearing aid(s)** Left ☐ Right ☐ N/A ☐ **Speech limitation** Yes ☐ No ☐ **Cognitive impairment** Yes ☐ No ☐ 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. Refer to 'Hospital Passport' if available.	If the child/young person/parent uses sign language please record if British/Irish sign language or Makaton	
Aspects of Life	**Normal/usual routine**	**Nursing Assessment**	**Assessment Need Identified**
Pain	**On admission is the child/young person in pain?** Yes ☐ No ☐ **Has the child/young person had recent acute pain?** Yes ☐ No ☐ **Suffer from chronic pain?** Yes ☐ No ☐ **Has the child/young person taken any analgesia prior to admission (if yes what was it?)** **_____** **Is there anything the child/young person does at home that helps manage pain that we can provide?** Yes ☐ No ☐ **Normal strategies for dealing with pain?**	**Pain Score:** See PEWS Chart	

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 ☐ No ☐ Condition of mouth: _____ Appetite: Usual diet: Thickener Yes ☐ No ☐ Supplements Yes ☐ No ☐ Breast Feeding _____ Formula _____ Cup/Bottle _____ Requires help with food Yes ☐ No ☐ Enteral feeding Yes ☐ No ☐ Nasogastric Yes ☐ No ☐ Fluid restrictions Yes ☐ No ☐	**Complete STAMP** **Last ate:** **Last drank:** **Food Allergies (specify):** **Nausea/vomiting at present:** Yes ☐ No ☐ **Any difficulty swallowing:** Yes ☐ No ☐ **If help is required please ensure child/young person is identified using your Trust process (e.g. a placemat).** **Enteral Device Type:** _____ **Enteral Device size:** **_____ cm** **Due changed: _____**	
Eliminating	**Prior to admission any problems with:** **Bowel** Yes ☐ No ☐ **Bladder** Yes ☐ No ☐ **Nappy/toilet trained/incontinent** (delete as appropriate) **Requires assistance with Toileting** Yes ☐ No ☐ N/A ☐ **Catheter** Yes ☐ No ☐ Size: _____ **Urostomy** Yes ☐ No ☐ **Bowel actions/day:** (including history of constipation) _____ **Type of Bowel Action: -** Bristol Stool Chart _____ **Stoma** ☐ **Drains in situ** ☐	**Passing urine?** Yes ☐ No ☐ **Nappies wet?** Yes ☐ No ☐ **(Weigh nappies, if required)** **Urinalysis:** Yes ☐ No ☐ **Still to be obtained:** ☐ **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.					
DATE		/ /	/ /	/ /	/ /
TIME					
WARD					
STEP 1 - DIAGNOSIS					
Does the child have a diagnosis that has any nutritional implications	**Score**	**1st Assessment**	**2nd Assessment**	**3rd Assessment**	**4th Assessment**
Definite nutritional implications	**3**				
Possible nutritional implications	**2**				
No nutritional implications	**0**				
STEP 2 – NUTRITIONAL INTAKE					
What is the child's nutritional intake?	**Score**	**1st Assessment**	**2nd Assessment**	**3rd Assessment**	**4th Assessment**
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**	**1st Assessment**	**2nd Assessment**	**3rd Assessment**	**4th Assessment**
>3 centile spaces/≥3 columns apart (or weight, 2nd 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**	**1st Assessment**	**2nd Assessment**	**3rd Assessment**	**4th Assessment**
High Risk	**≥4**				
Medium Risk	**2-3**				
Low Risk	**0-1**				
Signature					

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	• Take action • Refer the child to a Dietician, nutritional support team of consultant • Monitor as per care plan
Medium Risk	• Monitor the child's nutritional intake for 3 days • Repeat the STAMP screening after 3 days • Amend care plan as required
Low Risk	• 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	**Is mobility impaired?** Yes ☐ No ☐ **Moving & handling:** **Aids used:**	**Complete Moving and Handling Risk Assessment.**	

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				
DATE	/ /	/ /	/ /	/ /
TIME				
WARD				
Is child/young person independent of all moving and handling activities?	Yes ☐ Assessment need go no further No ☐ Complete Assessment	Yes ☐ Assessment need go no further No ☐ Complete Assessment	Yes ☐ Assessment need go no further No ☐ Complete Assessment	Yes ☐ Assessment need go no further No ☐ Complete Assessment
Is child's/young person's weight within safe working load (SWL) of equipment?	Yes ☐ No ☐ If No, specify:	Yes ☐ No ☐ If No, specify:	Yes ☐ No ☐ If No, specify:	Yes ☐ No ☐ If No, specify:
Is equipment wide enough for Child/Young person's safety and comfort?	Yes ☐ No ☐ If No, specify:	Yes ☐ No ☐ If No, specify:	Yes ☐ No ☐ If No, specify:	Yes ☐ No ☐ If No, specify:
Does child/young person use a mobility aid? e.g. walking frame, wheelchair	Yes ☐ No ☐ If Yes, specify:	Yes ☐ No ☐ If Yes, specify:	Yes ☐ No ☐ If Yes, specify:	Yes ☐ No ☐ If Yes, specify:
Is the mobility aid available on the ward?	Yes ☐ No ☐ N/A ☐ If Yes, persons own: Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐ If Yes, persons own: Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐ If Yes, persons own: Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐ If Yes, persons own: Yes ☐ No ☐
Are there any handling constraints? e.g. pain, external attachments, fractures, behaviour, environment	Yes ☐ No ☐ If Yes, specify:	Yes ☐ No ☐ If Yes, specify:	Yes ☐ No ☐ If Yes, specify:	Yes ☐ No ☐ If Yes, specify:
Referrals to other professionals e.g. physiotherapist, occupational therapist, back care advisor	Yes ☐ N/A ☐ If YES, specify: Professional: _____ Professional: _____ Professional: _____	Yes ☐ N/A ☐ If YES, specify: Professional: _____ Professional: _____ Professional: _____	Yes ☐ N/A ☐ If YES, specify: Professional: _____ Professional: _____ Professional: _____	Yes ☐ N/A ☐ If YES, specify: Professional: _____ Professional: _____ Professional: _____
Care Pathway for Moving and Handling commenced	Yes ☐ N/A ☐	Yes ☐ N/A ☐	Yes ☐ N/A ☐	Yes ☐ N/A ☐
Signature				

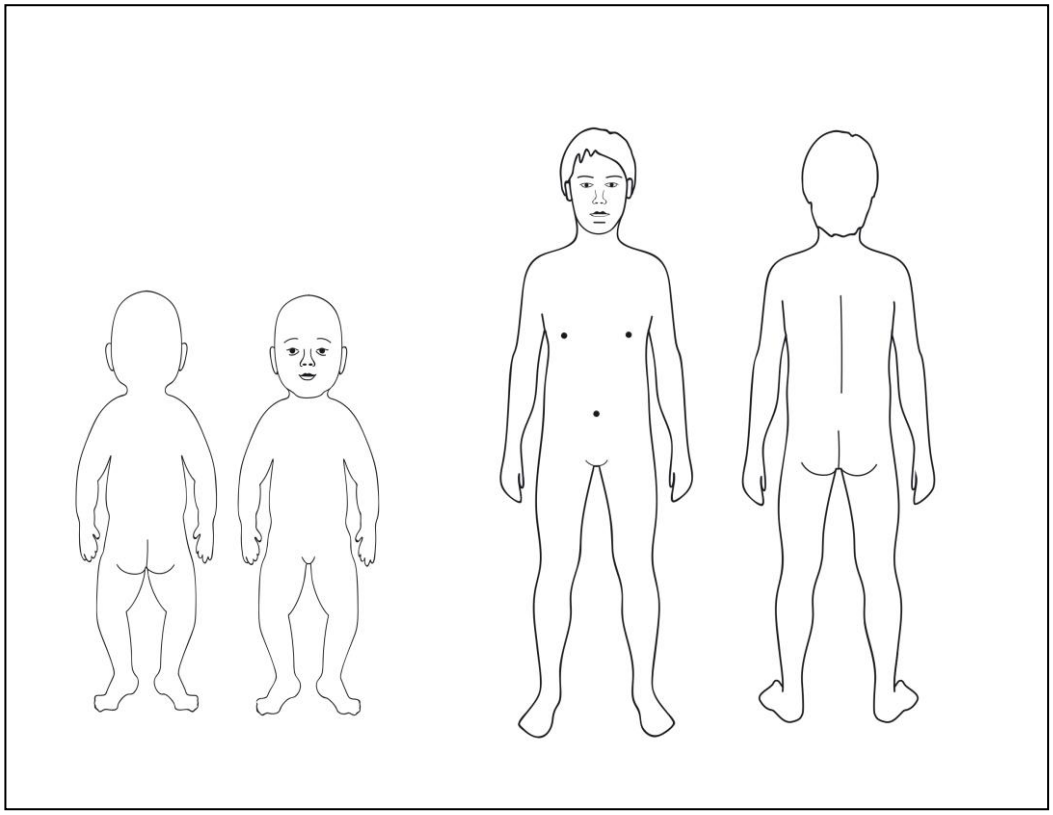
NURSING ASSESSMENT			
Assessment of aspect of life (Expand on any ticked boxes and link to Plan of Care)		**Specific Information** In this section record any additional information needed to support the development of your care plan including any detail related to readmission	
Aspects of Life	**Normal/usual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

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**	**1st Assessment**	**2nd Assessment**	**3rd Assessment**	**4th Assessment**
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 > 38ºC >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 10th 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 '<u>AT RISK</u>' of pressure damage						
ACTION TAKEN? Yes or No - document in nursing record						
Signature						

Body Table and Map

Document pressure damage/other 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

CODE	TYPE
BE	Blanching erythema
G1	Grade 1 pressure damage Non blanching erythema
G2	Grade 2 pressure damage Shallow crater/serous blister
G3	Grade 3 pressure damage Subcutaneous fat visible
G4	Grade 4 pressure damage Full thickness damage
DTI	Deep tissue injury Discoloured, eschar

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 ☐ No ☐ N/A ☐ **Comforter used** Yes ☐ No ☐ **Parent staying if admitted?** Yes ☐ No ☐	**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 **(Where age appropriate complete this section in confidence with Child/Young Person)**	**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/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 _____

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

CHILD/YOUNG PERSON CENTRED CARE PLAN						
Date	**Time**	**Problems / Potential Problems**	**Goal**	**Nursing Care Intervention**	**Review Date**	**Signature & designation**

RECORD OF NURSING CARE & OUTCOMES OF CARE			
Date	**Time**		**Signature & designation**
Record relevant telephone, face to face communication with patient / relatives / carers			

RECORD OF NURSING CARE & OUTCOMES OF CARE			
Date	**Time**		**Signature & designation**
Record relevant telephone, face to face communication with patient / relatives / carers			

RECORD OF NURSING CARE & OUTCOMES OF CARE			
Date	**Time**		**Signature & designation**
Record relevant telephone, face to face communication with patient / relatives / carers			

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 ☐ No ☐ Reason: _____				
Safeguarding discharge meeting convened	Yes ☐ No ☐ 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: _____

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
NNU	Neonatal Unit
PVL-SA	Panton-Valentine Leukocidin *Staphylococcus Aureus*
PEG	Percutaneous Endoscopic Gastrostomy
PEWS	Paediatric Early Warning Score
RSV	Respiratory Synctyial 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
VRE/GRE	Vancomycin/Glycopeptide Resistant Enterococci

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