Children's Health Ireland

Crumlin | Temple Street | Tallaght | Connolly

CHI NURSING PRACTICE GUIDELINE ON THE COMPLETION OF THE NURSING ADMISSION ASSESSMENT

Area of use:	All of organisation ☒	CHI at Connolly ☐	CHI at Crumlin ☐
		CHI at Tallaght ☐	CHI at Temple Street ☐
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Approved by & title:	Nursing Documentation Approval Committee October 17th 2023		
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Version History

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1.0 Guideline statement

Patient assessment is the systematic and continuous collection, organisation, validation and documentation of information (Berman et al., 2010). It is a deliberate and interactive process that underpins every aspect of nursing care (Heaven & Maguire, 1996). It is also seen as the cornerstone of individualised care, a way in which the uniqueness of each patient and their family can be recognised and considered in the care process (Holt, 1995). Effective patient assessment is integral to the safety, continuity and quality of patient care.

Nurses are professionally and legally accountable for maintaining a good standard of practice in relation to documentation and record keeping (NMBI, 2015). This includes completing an accurate assessment of the person's physical, psychological and social well-being, and, whenever necessary, the views and observations of family members in relation to that assessment (NMBI, 2015).

The Model for Nursing used is the Nottingham Model of care using Roper, Tierney Logan and the Activities of Living. The Nottingham Model is described by Smith[1] (1995) as an extension of the Roper Tierney Logan Model involving the parent and child in their own care making the nursing care as patient/family-centered as possible.

This guideline aims to support and standardise the nursing assessment and documentation process for patients across Children's Health Ireland.

2.0 Scope

Applies to all registered nurses and nursing students.

3.0 Procedures

- A Nursing Admission Assessment Form for (Infant or Child) should be completed for all inpatients within 24 hours of admission. Short stay surgical admission forms may be continued for short stay surgical patients only.
- The admitting nurse is responsible for ensuring that a baseline patient assessment is completed on admission and the findings are documented.
- Parent and/or guardians should be involved in this process to ensure physical, psychological, spiritual, social and cultural factors are considered.
- The more complete the information you provide the better knowledge everyone will have of the infant/child.

[1] Smith F (1995) Children's Nursing in Practice; The Nottingham Model, Blackwell Science, Oxford, UK.

3.1 Completing the admission assessment document

	Completing the Nursing Admission Assessment document *The nursing assessment will trigger the need to use a care plan specific to the child/infant's needs, if this is the case please complete the care plan as required.*
Patient details	This begins the story of this child's journey through the hospital. This is the opportunity to get the starting information correct. When you meet the patient and family this is the opportunity to welcome them and use 'Hello my Name is….' Introducing yourself and the clinical area highlighting it in the best possible light. There is a reason for each question in the nursing assessment, subject matter experts from across CHI have agreed on the content of this nursing assessment document.
Addressograph	An addressograph label taken from the HCR must be placed on this box. In the event there is no addressograph this detail can be hand written. Check the addressographs are the correct ones for the child with the healthcare record, make sure names and details on the addressograph match.
Date of admission, admitted from	These details need to be included, this information will be used for audit purposes.
Identity band	The identity band (ID) must be placed on the child's arm or leg taking care not to have it too tight, be sure the sharp edges-excess will not cut the child- cut them off, you should be able to slip your little finger between the ID band and the infant/child's wrist or ankle. Two ID bands are required for all patients attending the Operating theatre and under two years of age. Minimum Patient Identification for CHI is patient Name and Healthcare record number/Date of Birth.
Gender and religion	Give as much information as possible, if the parent/patient wishes to express their gender in a certain way make sure you detail this on the assessment.
Weight and height	This information must be double checked with a qualified staff member as medication is prescribed based on the correctness of this detail, most infants or children are reweighed on arrival to the clinical area even though they have been weighed in the ED, this is to ensure the same device is used to weigh after a few days following admission if required.
Next of Kin, Public Health Nurse and Pharmacy	Next of Kin must be completed. Sometimes it is best to write it in manually. Care must be taken here with the guardianship of the child as the guardian only has the right to sign the consent. So if an infant is admitted with parents with different surnames keep in mind that they may not be married and therefore the mum may be the only legal guardian. Ask advice here if there is any query before approaching parents as this may be a sensitive subject. If the public Health nurse and General Practitioner (GP) information is not known to the parent then write that in, they may not have had need for a GP or Public Health Nurse (PHN) yet. This information can be updated over the course of the admission if that information is obtained or prior to discharge.
Presenting complaint	Give a brief history of the current illness that has resulted in the admission of the patient **i.**e. bronchiolitis, abdominal pain, fractured radius etc. Detail how long the symptoms have been present and if s/he has been reviewed and treated by GP or in another hospital for this illness.
Relevant Health History	• Seek more background history from parent or guardian.

	• Ascertain birth details for infants e.g. hospital of birth, birth weight, gestational age, Apgars, any post natal treatment and on-going care. When the child is older it is not necessary to go back to all this history is it is no longer relevant. • Does the patient have any other on-going conditions? e.g. asthma, epilepsy, chronic lung disease, etc. • Ask what other specialists s/he is attending and if s/he has upcoming appointments in the service. • Consider informing other specialists of patient's admission, ask senior nurse if unsure. • What home treatments do they require for these conditions e.g. home oxygen, suction, physio?
Allergies	• Essential to obtain accurate information from child/parents**.** • Document any allergies that the child may have e.g. drug allergies, latex, certain tape or dressings, food (nuts, eggs, fish etc.), pollen, dust or previous reactions to blood products. • Be sure to report any serious allergies or drug reactions as per the parents history to Nurse in charge and/or Medical team. Document any signs and symptoms e.g. rash, urticaria, swelling, redness etc.
Medications on admission	• Discuss with patient / parents as many children require regular on-going drug treatment at home. • Ask parents for copy of current drug prescription, if available, or check the accompanying medication bottle labels for dose and frequency of medications. • Ensure the medications are recorded in mgs not mls (where possible) as varying strengths of medications are available. • If up to date prescription or medication bottles are not available on admission, request from parents or if in doubt check with their local community pharmacist.
PEWs Score	It is essential to get a baseline PEWs assessment on admission. Explain the Paediatric Early Warning Tool (PEWs) to the parents and explain the parental concern. Assure the parent that their input is welcomed.
Pain Assessment	• A pain assessment is necessary to use as a baseline. A pain score must be recorded. If a child/infant has pain on admission then they should be reviewed and analgesia given as a priority and a plan put in place for ongoing pain management. • 30 minutes following the administration of analgesia a repeat pain assessment should be completed, • If there is no reduction in pain or if the pain level remains the same a repeat review should take place. This should be repeated as required during their admission.
Maintaining a safe environment	• The ward layout and facilities are explained to the parent/guardian and patient. Any specific safety needs – parent asked if sleeps in bed or cot and implications, does the child sleep walk, fall from bed, have difficulty sleeping at night, these are essential pieces of information to help manage the infant/child nightime routine. Does the child have a comforter and have they got it with them. • Will parents stay with the child – parent's accommodation is offered and the opportunity to stay in the room is mentioned if parent wishes to stay with the infant/child and if that is possible. • Safety in terms of Personal Protective Equipment (PPE), safety checklists in the room, equipment checks are all essential.
Maintaining and controlling body temperature	Temperature checked on admission and parent/guardian asked if an anti pyretics was given. If timeline allows from prior dose and medication prescribed give a dose to reduce pyrexia. Of note if a child in your care has been given a medication to lower temperature, then you must recheck temperature in 30 mins and then hourly thereafter.

Washing and dressing	• Is the child self caring/independent. Answer the questions asked in the assessment and they give guidance to the next steps. Does the child like a bath or shower; and what is their routine. • If the child needs a wound assessment or has pressure areas that require attention or bruises these are documented. • An assessment of the oral cavity and the need for a tool is completed.
Infectious diseases	Complete the infectious disease section. This will give assurance that the patient is nursed in the correct bed, room or isolation protecting them and the other patient in that clinical area. If there are any queries here you must inform the senior nurse on duty and discuss with Infection Prevention and Control Team (IPCT) if any doubt. REMEMBER the need to include those that have been hospitalised aborad.
Vaccinations	• Complete the patient's vaccination schedule as this may be relevant for patient diagnosis e.g. pertussis, measles. • Whether the patient has received their vaccinations or not may determine what ward the patient is admitted to. • Vaccination schedule changed in October 2016, ensure you record in most appropriate section to patient's DOB. See link below for more information on childhood immunisation schedule http://www.hse.ie/eng/health/immunisation/pubinfo/babychildimm/Immschedule/ • Many of the patients admitted to CHI at Temple St. may have a chronic condition (metabolic disorders, renal disorders etc.) and are more at risk of contracting infectious illnesses. As a result, many of these children receive other vaccinations e.g. Rotavirus, Varicella, Pneumococcal and Influenza. • Tick the relevant boxes and enter the date when received (month/year). • If the patient has a chronic condition or history of prematurity, s/he may require the vaccination for Respiratory Syncytial Virus (RSV) during the RSV season. • This vaccine is given monthly. Therefore, it is important to determine how many doses the patient has received and the date it is next due. • New-born Screening should be completed for all children less than 1 year. If receiving an infant from a maternity centre, ensure this detail is handed over by transferring nurse. • If a repeat screen is required, document the date for repeat screen. • Sickle cell status – this needs to be determined for all patients of African origin and also to a lesser degree Indian and Middle Eastern origin. Patients who are Caucasian will not be affected by sickle cell disease. • Any gaps in any of the above information must be outlined to ensure treatment is given, vaccinations organised, or information passed on to both the parent and the GP.
Breathing	• Any history of breathing problems – asthma, bronchiolitis, pneumonia, muscular dystrophy, central hypoventilation syndrome? • Does s/he require respiratory support at home? Give details e.g. home oxygen, %, Continuous Positive Airways Pressure (CPAP), airway suctioning?
Airway	Assess if the patient has a normal patent airway and do they require artificial airway, tracheostomy, nasopharyngeal airway or stents to maintain their airway • Is the patient's airway dependent on positioning e.g. prone positioning for Pierre Robin sequence? • Does s/he have an audible stridor or wheeze? • Has s/he been diagnosed with airway abnormality e.g. tracheomalacia, subglottic stenosis, haemangioma, choanal atresia or obstructive sleep apnoea? • Document the Artificial Airway type – tracheostomy brand, size, date inserted, date changed or nasopharyngeal tube brand and size.

Elimination	• Is the patient toilet trained or still wearing nappies? • Does s/he pass urine normally or require catheterisation? • Is s/he receiving Renal Replacement therapy? Give details re type and frequency. • Does s/he have a normal bowel habit? • How often does s/he pass stool? • Does s/he require stool softeners, laxatives, bowel washouts? • Does s/he have a stoma? Give details e.g. ileostomy, colostomy. • If patient is female, has she commenced menarche? What was the date of last menstrual period? Report to senior nurse or medical team if this is unknown and patient is scheduled for procedure e.g. surgery, CT scan.
Eating and drinking	• If patient is an infant, what type of feeding is s/he receiving, if on formula what brand is it? • How many mls or ounces per bottles and how many bottles are taken over the day e.g. 7 oz. x 5, does s/he use a special type of teat? • Are there any additives required for feeds e.g. carobel, gaviscon etc.? • What kind of food consistency does the patient like e.g. normal regular diet, soft diet or other special diet? • What are the patient's likes and dislikes e.g. likes chicken & carrots, dislikes fish & mushrooms? • Are there any sensory issues around food textures, foods touching ets? • Is the patient fasting on admission, document last time patient ate and drank? • Is assistance required with feeding e.g. full assistance, likes to use own spoon but fed by mum at same time? • Feeding issues – e.g. poor gag, swallow, prone to aspiration, gastro oesophageal reflux disease (GORD), fed by gastrostomy only. • Takes medication orally – if not is it given via Nasogastrically (NG), Percutaneous Endoscopic Gastrostomy (PEG), and Percutaneous Endoscopic Jejunostomy (PEJ)? • If the patient has a feeding tube, give details of type and when it was inserted? • If other specific details are required, record in blank section e.g. requires full Parenteral Nutrition (PN), details in relation to specific dietary restrictions e.g. metabolic disorder, diabetes etc. • If the child is linked in with dietician or speech and language services, document details in additional information section.
Communication	• Does the patient have any problems with his /her sight, hearing or speech and how severely is s/he affected? • If so, what aids are used to help communicate his / her needs? • Is s/he attending any support services?
Mobility	• What is the patient's muscle tone like? • Is s/he hypotonic e.g. poor head control, floppy? • Is s/he hypertonic e.g. stiffness? • Is her / his movement age appropriate? • Depending on age and medical condition, s/he may require partial or full assistance in Activities of Living (ALs).
Play and learning	• What is the patient's level of understanding and comprehension? • Is it normal for age? • Does the patient have a diagnosed learning disability? • What is his / her Glasgow Coma Scale score (GCS)?

	• Level of education details – does s/he attend nursery, crèche, or school? • Is s/he being cared for at home or by child-minder?
Sleep and comfort	• Does the child sleep in a bed or cot? • If the patient is being transferred from neonatal unit, s/he may be nursed in an incubator. • Does s/he use side rails at home? • Does s/he sleep with pillow; sleep alone or with a sibling or parents? • Does the child use a comforter e.g. soother, favourite toy, specific blanket? • What is his / her usual sleep and nap pattern e.g. sleeps from 7pm to 8am with 2 x 30 minute naps during the day (11am and 3pm) • If indicated, carry out a pain assessment, if patient is distressed, post op, has wound drains etc. Document score on most age appropriate pain score tool.
Pressure area assessment	• Complete the local Pressure area assessment if required using a validated tool in children. • Has the child reached puberty and are there any special needs • Has the child commenced Menarche • If commenced menarche please give detail of last period. Consider if a pregnancy assessment is required and refer to the pregnancy assessment guideline
In hospital	This section leaves space for details of other Health and social Care Professionals to assist the patient journey. When it comes to the time the patient needs to be discharged this information will be vital to ensure the completeness of the discharge and patient readiness.

4.0 Monitoring, audit and evaluation

This PPPG will be reviewed and updated at least every three years by the document author/owner, or earlier if required due to updated guidance, evidence or legislation. Compliance with key principles or procedures described within this PPPG should be audited on an annual basis. Quality Care Metrics audits nursing practice through nursing sensitive indicators on a monthly basis.

5.0 Key stakeholdersz

The following key stakeholders were involved in developing and/or reviewing this document:

This document is a compilation of guidance documents from Temple Street, Crumlin and Tallaght and is based on the revised Nursing Assessment document agreed across the sites.

Name	Title	Department
Susan Keane	CNM 3 Nursing Practice Temple Street	Nursing Practice
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Fionnuala O' Neill	NPDC PPGs for CHI	Nursing Practice
Sent to nursing in Temple street, Tallaght, Crumlin for feedback in 2022, 2023		
Members of the CHI Nurse Practice Committee June 2023		

6.0 Communication and training

All approved Policies Procedures Guidelines (PPG) will be available on the CHI at Crumlin website. https://www.olchc.ie/ Heads of Department and Line Managers must ensure that their staff are aware of all PPGs relevant to their role. Where required, training should be provided on the contents of this PPPG.

7.0 References and Bibliography

Berman, A., Kozier, B. & Erb, G.L. (2010). *Kozier and Erb's Fundamentals of Nursing*. Frenchs Forest, NSW: Pearson.

Heaven, C.M. & Maguire, P. (1996). *Training hospice nurses to elicit patient concerns*. Journal of Advanced Nursing, 23, 280-286.

ONMSD, HSE (2018) *National Guideline for Nursing and Midwifery Quality Care-Metrics Data Measurement in Children's Services* https://healthservice.hse.ie/filelibrary/onmsd/national-guideline-for-nursing-and-midwifery-quality-care-metrics-data-measurement-in-childrens-services.pdf

Holt, P. (1995). *Role of questioning skills in patient assessment*. British Journal of Nursing, 4, 1145-1148.

Nursing & Midwifery Board of Ireland (2015). *Recording Clinical Practice: Professional Guidance.* NMBI. Dublin.

Smith F (1995) *Children's Nursing in Practice;* The Nottingham Model, Blackwell Science, Oxford, UK.