ADMITTING A PATIENT TO THE WARD: NURSES ROLE IN ORIENTATING FAMILIES/CARERS

PROCEDURE ©

DOCUMENT SUMMARY/KEY POINTS

- Admission of a patient to the ward is a valuable time to engage the families in the patient's care needs
- One (1) appropriate size white identification band with black writing or a clear identification band with a white insert with black text
- If the patient has a documented drug/food/tape allergy and/or adverse reaction to a medicine, a red identification band with a white panel and black text should be applied. The allergy is not to be recorded on the band
- Assess if the parent//care requires the interpreter service (via telephone: 1300131450 or face to face booked appointments: 99123800) or referral to the Aboriginal Liaison person (53630 Pager:7256)
- Parents/carers must be advised on how to escalate concerns about their child's clinical condition Medication history should be taken on admission and patients own medications should be sent home.
- Infectious status must be established, escalated and appropriately accommodated
- All patients must commence on the age appropriate Standard Paediatric Observation Chart (SPOC).
- Initial paediatric admission assessment must be completed within 4 hours
- Paediatric admission assessment form must be completed within 24 hours
- Post procedure checklist following surgery
- Paediatric Risk Assessment Tool (PRAT) must be completed within 4-6 hours of

admission to the ward.

- All risks should be identified with staff/ Parent/ Carer and care actions discussed

CHANGE SUMMARY

Outline a summary of changes to the revised document.

- Inclusion of the PRAT tool.
- Brief information concerning Aboriginal and Torres Strait Islander peoples and families with limited literacy skills.
- Remove information pertaining to Day Stay wards
- Inclusion of CERS (Between the Flags/SPOC)
- Inclusion of process for escalation of care by parents/carers
- Inclusion of paediatric admission assessment form

READ ACKNOWLEDGEMENT

Outline who needs to read or know about the document:

- Read Acknowledge Only – All ward nursing staff are required to read and acknowledge the document.

Introduction

Admitting a patient to the ward is an important step in the care of the child. This is a valuable time to gain baseline information about the patient, but also an opportunity to orientate the family to the ward and the patient's care needs.

Patient identification

Correct identification of a patient promotes patient safety and prevents complications including wrong procedures, medication errors, transfusion errors and diagnostic testing errors.

The primary purpose of a patient identification band is to identify the patient wearing the band.

Identification bands are a critical tool to prevent errors associated with mismatching patients and their care. Identification bands contain important information about the patient and are essential for establishing and checking identity of the patient throughout the care process.

- When applying the identification band, the three (3) core patient identifiers must be documented and verified with the Patient/ parent / carer:
    - MRN
    - Full name
    - Date of birth
- Apply one (1) appropriate size white identification band with black writing or a clear identification band with a white insert with black text.
- If the patient has a documented drug/food/tape allergy and/or adverse reaction to a medicine, the White ID band is replaced with a red identification band with a white panel and black text. The allergy is not to be recorded on the band. Staff are to refer to the patients records for this information.
- Hand written labels are only to be used when printed labels are not available and must include the three core identifiers.
- If a newborn baby has not been given a name yet the family name of the mother should be marked followed by "baby of…(mothers given name)".
- Patients having surgery/ procedures outside the unit/ward must have 2 ID bands applied to opposite limbs.

Orientation to the ward

Should be obtained within 12 hours of admission to the ward and staff are encouraged to perform the following actions:

- Introduce yourself to parents/ carers and the patient.
- Staff should assess if the parent/carer requires the interpreter service (via telephone: 1300131450 or face to face booked appointments: 99123800) or referral to the Aboriginal Liaison person (53630 Pager:7256)

- Orientate to ward layout, routines, availability of parents' hostel and other facilities eg. Toilets/ ATM/ cafeteria etc.

  Note: This may require staff to walk to these destinations to show parents/carers the facilities for parent/ carers who may have poor literacy or of a non-English speaking background.

- Advise parents/carers of the processes for escalating clinical concerns. As per Between the Flags- Clinical Emergency Response System policy
- Complete initial paediatric admission assessment in the electronic medical record, which includes allergies, weight, height, infectious contacts and confirmation of identification.
- Complete paediatric admission assessment form which includes comorbidities, immunisation status, nutritional screening tool and general nursing history
- If the parents/ carers have brought their child's medications to hospital, staff are to encouraged to inform the parents/ carers to take them home (excluding Turner Ward). Some ward may lock medications away, please refer to local guidelines
- Staff are to inform parents/ carers not to administer own medications to their child. All administrations of medications whilst in hospital should be checked and signed by nursing and medical staff.
- Document any clinical concerns in the child's progress notes
- Document any social and developmental concerns within the Clinical Progress Notes and escalate to the relevant clinical staff where appropriate.
- Clarifying any infectious contacts with the family is essential, as patients may need to be moved or isolated to ensure they are not an infection risk to other patients, as per policy Infection Control – Isolation at CHW
- Infectious patients must have appropriate sign/s applied to door of room indicating precautions. Alert to infectious status needs to be communicated to ward before admission if known.
- Measure and record weight and length (height) within 4 hours of admission, this MUST be entered into power chart, as per Nutrition Care Policy
- All patients must be commenced on the aged appropriate Standard Paediatric Observation Chart (SPOC). A full set of observations must be documented on admission/ transfer to the ward. Escalate concerns, as required.
- Discuss and negotiate care needs for the patient, including what will be shared and who will deliver these cares. Families are encouraged to continue to be a part of the care team.
- Keep the family informed of any progression in care – such as surgery times and NBM status etc.
- If the patient is undergoing a surgical procedure, ensure a consent has been completed by medical staff t and a pre-operative check list completed. A pre scan questionnaire needs to be completed if the child is having a MRI.
- All patients returning from Surgery must have a Post Procedural Checklist completed in PowerChart (How to enter AdHoc charting documents in PowerChart).

- All patents must have a risk assessment completed in PowerChart - Adhoc Charting – Paediatric Risk Assessment Tool (PRAT) within 6 hours of admission to the ward, as per policy. These include:
    - Falls assessment
    - Pressure injury Assessment
    - Behavioural Assessment
    - Manual Handling Assessment
- Any identified risks should be communicated to staff and families. Appropriate care actions should be implemented and documented it the clinical notes
- Patient's nutritional status. Complete nutritional screening tool as part of the paediatric admission assessment form
- Estimated Date of Discharge (EDD) must be identified in the Patient Management System (PAS).
- Discharge planning risk assessment form must be completed within the first 24hrs of admission

Allergy Status

- A discussion with the Parents/ carers must occur regarding any allergies or Adverse Drug Reactions, their child may have.
- Medical staff, Nurses and pharmacists have an important responsibility to ensure ADRs are documented and reviewed for accuracy and any supplementary information added if appropriate.
- Red armbands indicate an allergy and needs to be placed on the arm of all children with both drug/food/tape allergies. In routine admissions all allergies as stated by the patient or parent should be recorded in both the clinical notes and recorded in PowerChart.
- Allergies must be reviewed by the medical officer before any medications are charted and administered, as per Adverse Drug Reaction Guidelines.
- Food allergies need to be entered into the patient management system