

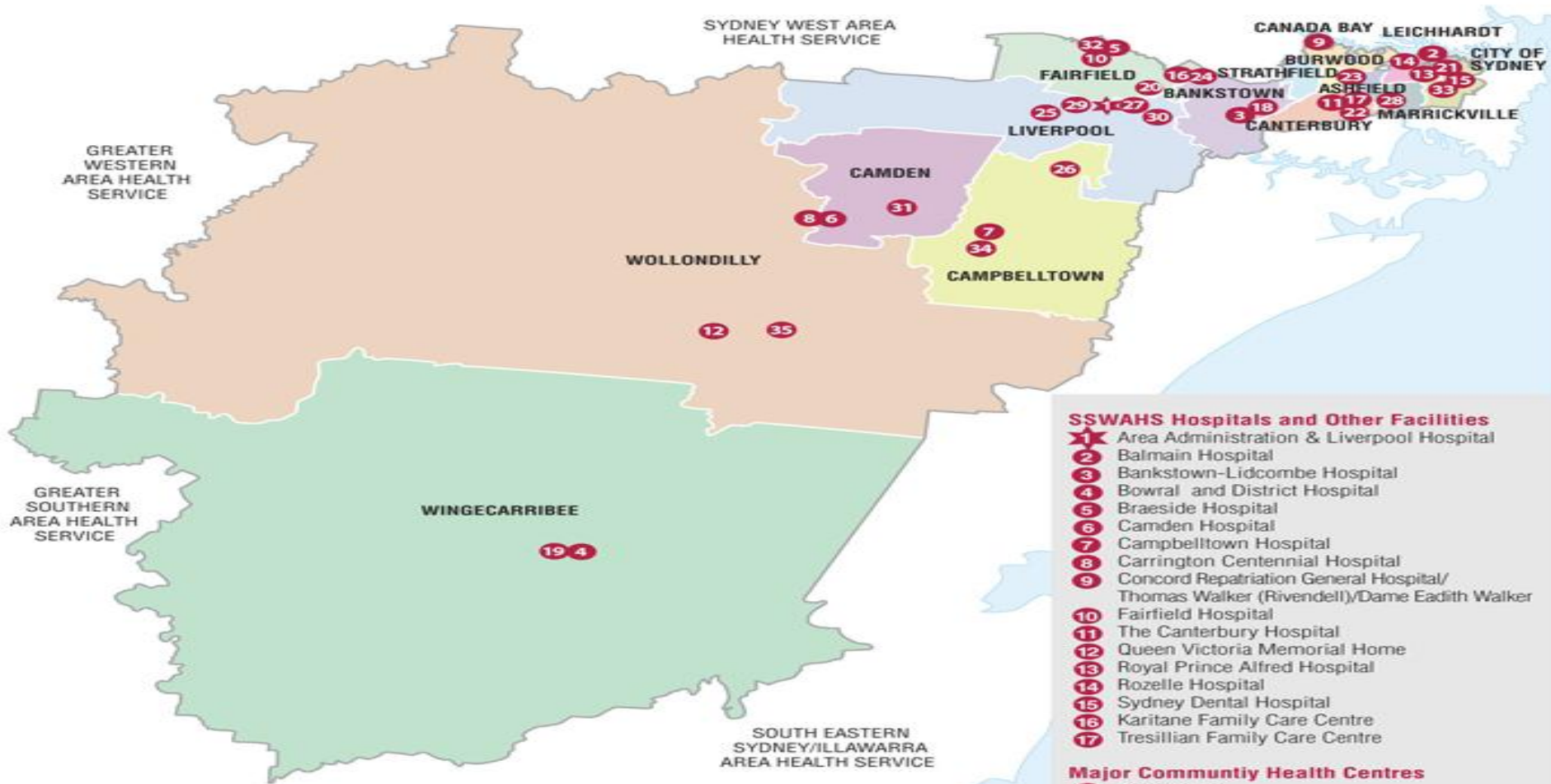
Sydney South West Area Health Service

NORTHERN SYDNEY/CENTRAL COAST
AREA HEALTH SERVICE

SYDNEY WEST AREA
HEALTH SERVICE

GREATER
WESTERN
AREA HEALTH
SERVICE

GREATER
SOUTHERN
AREA HEALTH
SERVICE



SSWAHS Hospitals and Other Facilities

- ★ Area Administration & Liverpool Hospital
- 2 Balmain Hospital
- 3 Bankstown-Lidcombe Hospital
- 4 Bowral and District Hospital
- 5 Braeside Hospital
- 6 Camden Hospital
- 7 Campbelltown Hospital
- 8 Carrington Centennial Hospital
- 9 Concord Repatriation General Hospital/ Thomas Walker (Rivendell)/Dame Eadith Walker
- 10 Fairfield Hospital
- 11 The Canterbury Hospital
- 12 Queen Victoria Memorial Home
- 13 Royal Prince Alfred Hospital
- 14 Rozelle Hospital
- 15 Sydney Dental Hospital
- 16 Karitane Family Care Centre
- 17 Tresillian Family Care Centre

Major Community Health Centres

- 18 Bankstown
- 19 Bowral
- 20 Cabramatta
- 21 Camperdown
- 22 Canterbury
- 23 Croydon
- 24 Fairfield
- 25 Hoxton Park
- 26 Ingleburn
- 27 Liverpool
- 28 Marrickville
- 29 Miller
- 30 Moorebank
- 31 Narellan
- 32 Prairiewood
- 33 Redfern
- 34 Rosemeadow
- 35 Tahmoor

Local Government Areas

Ashfield	Fairfield
Bankstown	Leichhardt
Burwood	Liverpool
Camden	Marrickville
Campbelltown	Strathfield
Canada Bay	Wingecarribee
Canterbury	Wollondilly
City of Sydney	

Edition - March 2006

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Entrance to Paediatric Pod



The P Pod



6 monitored bed spaces



Nurses station/ procedure room entrance



Procedure room



Procedure room



Corridor entrance



BYDNEY SOUTH WEST AREA HEALTH SERVICE NSW HEALTH

PAEDIATRIC EMERGENCY DEPARTMENT FLOW CHART

SURNAME: _____ MRN: _____
 OTHER NAMES: _____ MALE FEMALE
 D.O.B. / / M.O.
 ADDRESS: _____
 LOCATION: _____
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAIN SCORE – SELF ASSESSMENT

No Hurt Hurts Little Bit Hurts Little More Hurts Even More Hurts Whole Lot Hurts Worst

0 2 4 6 8 10

PAIN SCORE – FLACC PAIN SCALE (BEHAVIOURAL)

	Score 0	Score 1	Score 2
FACE	No Particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
LEGS	Normal position or Relaxed	Uneasy, Restless, Tense	Kicking, or Legs drawn up
ACTIVITY	Lying quietly normal position – moves easily	Squirming Shifting back / forth / tense	Arched Rigid or Jerking
CRY	No Cry (Awake or Asleep)	Moans or Whimpers Occasional Complaints	Crying Steadily Screams or Sobs Frequent Complaints
CONSOLABILITY	Content Relaxed	Reassured by occasional touching, hugging or talking to distractible	Difficult to console or comfort

This score chart is used for the non-verbal child – adding the scores of each of the five points together from 1 - 10

INJURY & PAIN CHART

A = Abrasion H = Haematoma
B = Burn L = Laceration
C = Contusion P = Pain
D = Deformity S = Swelling
E = Bruise

Please indicate injury, or pain on the body chart. Complete a circulation observation chart where appropriate.
 Indicate approximate size of injury where appropriate (i.e. laceration, burns, contusions)

BURNS CALCULATIONS
 For every year of life after 12 months take 1% away from the head and add 1/2% to each leg until the age of 10 years old.
 Adult Proportions used for children older than 10 years of age

Burns Fluid Calculations:
 • Wt (kg) x % body surface burn x 3.4mls = 24 hours fluid
 • Give 1/2 this amount in 1st 8 hours from time of BURN!
 • Give remaining 1/2 over next 16 hours
 • Children weighing < 30kg should have maintenance fluids
 • Normal Saline 0.9% + 2.5% dextrose in addition to the burns resuscitation fluids.

ED Nurse Name: _____ Signature: _____

BYDNEY SOUTH WEST AREA HEALTH SERVICE NSW HEALTH

PAEDIATRIC EMERGENCY DEPARTMENT FLOW CHART

SURNAME: _____ MRN: _____
 OTHER NAMES: _____ MALE FEMALE
 D.O.B. / / M.O.
 ADDRESS: _____
 LOCATION: _____
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PRESENTING PROBLEM: _____ **DATE:** _____
Protocol Commenced: _____ **TIME:** _____

Weight: _____ kg **Allergies:** _____

IMMUNISATION UTD: YES NO **Comment:** _____

Next of Kin: _____ **Phone No:** _____ **Notified:** YES NO
Relationship: _____

Next of Kin: _____ **Phone No:** _____ **Notified:** YES NO
Relationship: _____

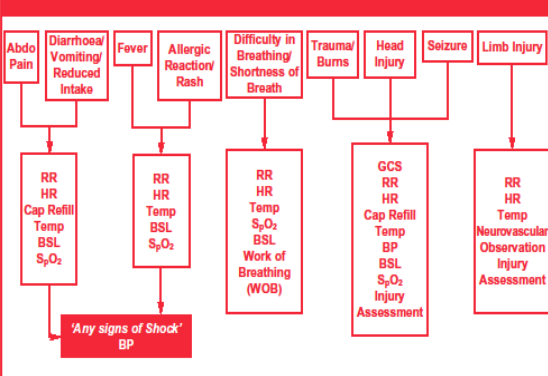
ADMISSION CHECK

Name Band Allergy Band Yes N/A First Net

Nurse's Name: _____ **Signature:** _____

Nursing Observations & Assessments on Admission
 For Patients That Present With 2 Or More Presenting Problems Ensure Observations And Assessments For Each Complaint Is Completed. Each Child Should Be Reassessed And F(4) Set Of Observation Completed At Any Change In Conditions. Continuous Vitals Should Be Repeated According To The Facilities Guidelines.

THIS IS ONLY A GUIDE. OBSERVATIONS SHOULD BE COMPLETED AND REPEATED AS CLINICALLY INDICATED.



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BYDNEY SOUTH WEST AREA HEALTH SERVICE NSW HEALTH

PAEDIATRIC EMERGENCY DEPARTMENT FLOW CHART

SURNAME: _____ MRN: _____
 OTHER NAMES: _____ MALE FEMALE
 D.O.B. / / M.O.
 ADDRESS: _____
 LOCATION: _____
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PATIENT WARD TRANSFER CHECK LIST

Date: _____ Time: _____ WARD: _____

- Ward RN receiving Hand Over: _____
- All Documentation Complete
 - a) Old Notes
 - b) Observation within 1 hour
 - c) Medication Chart
 - d) Fluid Balance up to date
 - e) IV Fluid Chart
 - f) Additional Charts _____
 - g) Progress Notes Up to Date YES NO Reason _____
- Nil By Mouth YES NO IVF
- Patient Sleeps in a COT BED
- Parent/Guardian aware of / present at Transfer: YES NO
- Recent Infectious Contact YES NO
Specify _____

ED Nurse Name: _____ Signature: _____

DISCHARGE CHECK LIST

	YES	NO	N/A
Is their cannula out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge Letter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge Script?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fact Sheet? Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma Action Plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ED Nurse Name: _____ Signature: _____

VALUABLES CHECK LIST

DESCRIPTION	NONE	SELF	SECURITY	PARENTS
Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jewellery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobile Devices (phone, ipod etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clothes (include cut off items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prohibited Items / Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

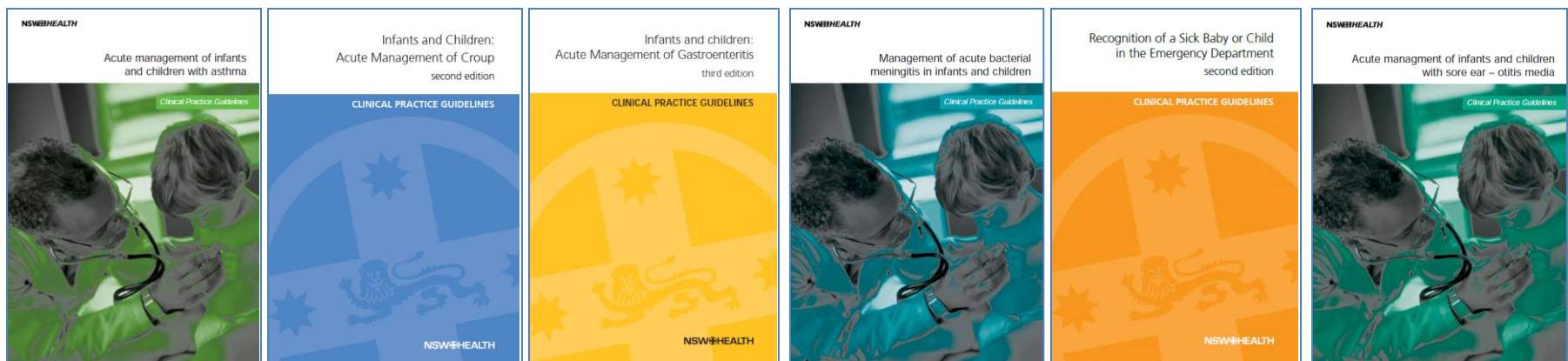
The Hospital takes no responsibility for any lost clothing. It also takes no responsibility for any loss or damage to valuables not lodged for safe keeping. Patients / Parents / Guardians are advised that all valuables (except clothing actually being used) should be sent home or locked in security.

Parent / Guardian / Patient's / Witness's Signature (please circle): _____
 Security No: _____ Nurse's Signature: _____

PAEDIATRIC EMERGENCY DEPARTMENT FLOW CHART (TRIAL) AMR 043.001



Paediatric Clinical Practice Guidelines



<http://www.ciap.health.nsw.gov.au/guides/guidelines/paediatric.html>