**Our Lady’s Children’s Hospital, Crumlin**

**Guidelines on the completion of the Nursing assessment sheet 1A.**

- Children admitted to MDU/SDU/HaemOnc DU, will be assessed on admission using the Nursing Assessment 1A.
- If children cannot be appropriately assessed using the Nursing Assessment 1, use Special Needs Assessment 2
- Please apply addressograph labels to patient details, next of kin and community services
- Each assessment is divided into subsections-prompt questions indicate the information required. Complete all details where possible or insert n/a as appropriate. Not all sections will be completed for every admission. Professional judgment of the admitting nurse should be used with individual patient assessment.

<table>
<thead>
<tr>
<th>Patient details</th>
<th>Apply addressograph label</th>
<th>Next of Kin</th>
<th>Apply addressograph label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete all fields requested</td>
<td></td>
<td>For this section please place an addressograph label or if not possible write in the required details. Check with Parent/guardian if details are correct.</td>
<td></td>
</tr>
<tr>
<td><strong>GP name and address</strong> If an addressograph is available place it here</td>
<td></td>
<td><strong>Vaccinations</strong> Complete all sections by inserting information and ticking the box required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Public Health Nurse</strong> Complete this section if information available, Health centre details if available or if not please state information not available</td>
<td></td>
<td>Menstrual history if applicable to be included Identity Band correct and in situ—Please circle if ID band in situ, if not then take this opportunity to ensure details are correct and apply name band. If for some reason no ID band can be applied please insert reason, for example allergy, burns, Eczema—please place ID band in an alternative visible site, on cot or bed head</td>
</tr>
<tr>
<td></td>
<td><strong>Weight</strong> on admission _________</td>
<td><strong>Height (Length)</strong> on admission _________ (if applicable)</td>
<td>Observations on admission are recorded.</td>
</tr>
<tr>
<td><strong>Allergies</strong> Please detail any allergies, state known allergen and describe detail of whether rash, wheeze, hives, puffy eyes, anaphylaxis, is an Anopen required</td>
<td></td>
<td><strong>Any contact with Infection in the last 4 weeks</strong> This is essential information, ask parent if any contact with infection such as measles, mumps, chickenpox et</td>
<td></td>
</tr>
<tr>
<td><strong>Medications on admission</strong> Insert details of medications, doses and times given, include route of administration, how the child takes his/her medications e.g. spoon, syringe etc.</td>
<td></td>
<td><strong>Previous History</strong> This section is for details of past medical history to date. Give as much detail as possible in chronological order.</td>
<td></td>
</tr>
<tr>
<td><strong>Reason for admission: Date</strong> Time: Only place exact reason for admission. Time and date must be included. Print full name of nurse completing the admission. This form can be reused for subsequent admissions up to six weeks from the first date of admission. If there is ANY change in the child’s condition or details, a new admission must be completed. The repeat admissions are reassessed by the admitting nurse, and signed by that nurse for that day. Please sign in chronological order 1 to 5.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Maintaining a safe environment
- This section should cover any specific safety needs required by the child/infant.
- Does the child require isolation for infection?
- Is supervision required, are parents present?
- Assess the child/infant pain score.
- Any requirements that may have safety implications must be included here.

## Personal Cleansing and dressing
- Tick the boxes required.
- Include any personal cleansing issue in this section.
- What condition are the child’s teeth in, is he/she teething?
- Does the child/infant suffer from a skin disorder?
- Any evidence of tanning/sunburn (SDU).

## Communication
- What is the child’s/infant’s name and what does he/she answer to?
- Does the child speak English, will a translator be require, if so insert language, what is the child’s first language?
- Does the child make strange sounds?

## Mobility and Posture
- Please tick boxes required.
- Does the child/infant require any specific pressure relieving devices?
- Does the child’s/infant’s condition affect their mobility?
- Is motor development normal for age?

## Breathing and Circulation
- Does the child/infant have an underlying respiratory or haematological condition?
- Does the child/infant require inhalers/nebulisers/oxygen?
- Use professional judgment in relation to required observations.

## Eating and Drinking
- Answer required questions, insert details such as likes for meals.
- Will child require meals?
- Record details of formula type, times, volume.
- Record details such as type of teat, spoon.

If any specialist requirements please insert, such as Halal, no pork, vegetarian, vegan, Peskatarian

## Controlling Body Temperature
- Does the child suffer from febrile convulsions?
- What interventions use at home to reduce pyrexia?
- When were antipyretics last given?

## Play and Education
- Please complete required questions.
- Is the child reaching normal milestones?

## Rest and Sleep
- Please complete details as requested, if any other specific information please insert same.
- Does the child sleep through the night?
- Is a day time nap required?

## Expressing Sexuality
- Keep in mind gender mixes in shared rooms.
- Is the child menstruating?
- Is it appropriate to ask LMP, or if commenced?

## Elimination
- Complete required fields.
- Is the child trained, or using pull ups/nappies?
- Any history of constipation/diarrhea?
- Are rectal washouts required, if yes how often and insert volumes.
- Urinalysis (renal patients on MDU, if applicable).

## Additional information
(Consider areas that may require special consideration such as ethnic or religious requirements if needed)

## Post-operative
- Complete all fields, inserting comments if appropriate.
- Date and sign all sections.
- Insert return to ward time on sheet.

## Discharge
- Complete all details, insert comments if appropriate.
- Observations on discharge are recorded, if appropriate.
- Refer to anaesthetic criteria for surgical patients.
- Record time of discharge and sign.

## Anaesthetic criteria
As agreed with anaesthetic team 2006. A registered nurse determines patient suitability for discharge. The child is assessed on whether he/she has returned to their admission condition. Any deviation from this requires anaesthetic review prior to discharge.