Assessment and Reassessment Policy for the pediatric patient in the Emergency Department

I. SCOPE

To establish the Nursing standards and process for assessment and re-assessment of the pediatric patient at ThedaCare Neenah Emergency Department.

II. PURPOSE STATEMENT

The goal of an assessment is to determine the care, treatment, and services that will meet the patient's needs. The assessment process will be used from the patient's initial presentation throughout the patient's care encounter to support continuity of care.

III. DEFINITIONS

A. **Assessment** is the comprehensive collection of data pertinent to the patient's health or the situation, including physical examination, risk assessment, safety assessment, and potential needs.

B. **Primary Assessment**: Will be completed on all patients, other than identified fast track patients. Assessments will be documented based off of patient exceptions and will include neurological assessment, respiratory assessment, skin assessment, and psycho/social assessment. Some of these Primary Assessments may be documented as abnormal, but consult with parents at the bedside to determine what is appropriate for the child and document if it is within the patient's normal parameters. The Primary Assessment is the responsibility of the primary RN upon initial contact with the patient or as soon as clinically possible.

1. **Neurological Assessment Within Defined Limits (WDL)**: Orientation, absence of confusion or mental status changes, verbalization clear and understandable, absence of spinal precautions, moves all extremities equally and spontaneously, absence of neuro tubes, drains, and appliances.
2. **Respiratory Assessment**: Patent, spontaneous symmetrical respirations, clear lung sounds, no cough, absence of supplemental oxygen or artificial airway, normal rate, absence of retractions, nasal flaring, or grunting, nailbeds pink, and absence of respiratory tubes, drains, and appliances.
3. **Skin Assessment**: Skin warm, dry, and appropriate for race, absence of open areas or wounds, and absence of integumentary tubes, drains, and appliances.
4. **Psycho/Social Assessment**: Social interactions appropriate for developmental age, interactions with environment appropriate for developmental age, and family pleasant, receptive, and supportive.
5. **Pediatric Abuse Risk Assessment**

C. **Focus Assessment**: detailed assessment of a specific body system, or several body systems, relating to the presenting problem or current concerns of the patient.

IV. POLICY

A. Assessment is an interdisciplinary approach, see Policy #568 for multidisciplinary patient assessment for disciplines other that nursing. The primary determinant of the "scope of assessment" to be completed initially and ongoing is determined by the patient's condition and diagnosis or health situation. All completed assessment data gathered are to be documented in the patient's electronic health record at the time of completion. Assessment data is a key component in communication between caregivers, as the patient flows from one department to another. The attending provider and/or surgeon are to be notified of any unstable change(s) in condition as evidenced by changes in assessment data.

V. PROCEDURE

A. Vital Sign Assessment/Reassessment:

1. Temperature / Heart Rate / Respiratory Rate / Pulse Oximetry on all patients.
2. Rectal temperature performed on ill children under age of 2.
3. Weight in Kilograms (without conversion from pounds) on all patients.
    a. Bed scale and standing scales should be zeroed prior to obtaining a weight
    b. Infant scale should be zeroed with a dry diaper prior to obtaining weight. Wet/ dirty diaper should not be on scale when obtaining weight.
    c. Infant should be weighted in dry diaper only.
    d. Be sure the entered weight does not flag for EPIC discrepancy. Re-collect if indicated.
4. Notify physician immediately for abnormal vitals. *see attached document for reference ranges*. Abnormal vitals need to be reassessed immediately. If they continue to be abnormal, the vitals indicator on the EPIC track board will be populated. If the patient is critical/unstable an immediate face to face discussion with the provider is necessary.
5. Vitals re-assessment and accurate documentation of heart rate, respiratory rate, and pulse oximetry hourly, unless condition warrants more frequent reassessments.
6. Blood Pressure
    a. Blood Pressure (BP) once on all patients 4 and over, unless condition warrants more frequent.
    b. Blood pressures on all ESI 1 every 15 minutes unless condition warrants more frequent.
    c. Blood pressure on all ESI 2 every 30 minutes unless condition warrants more frequent.
7. End Tidal CO2 monitoring if condition warrants; examples: seizures or decrease in mental status.
8. Cardiac Monitoring on patients if condition warrants.
9. Glasgow Coma Scale (GCS) obtained on any patient that presents to the ED for a traumatic nature. Reassess if changes in mental status. Examples include a fall, MVC, or maltreatment concerns.

B. Vitals Frequency:

1. May vary based on provider order, patient's condition and/ or specialty services.

2. Type of sedation/anesthesia used will determine frequency of vital signs. During a sedation vitals should be assessed minimum of every 15 minutes until pre-anesthesia mental status returns to baseline.

4. Vital Signs (VS) based on ESI Levels: A Vital Sign reminder will appear on the electronic medical record's tracker based on the patient's ESI Level.

a. ESI 1 requires vitals at a minimum every 15 minutes until stabilized.
b. ESI 2 requires vitals at a minimum every 60 minutes.
c. ESI 3 requires vitals as a minimum every 120 minutes.
d. ESI 4 and 5 at a minimum every 240 minutes.

5. Change in patient condition or mental status require a full reassessment of HR, BP, RR, Sp02, and glucose

6. 30 minutes prior to discharge

C. Pain assessment/reassessment:

1. A comprehensive pain assessment is conducted as appropriate to the patient's condition and the scope of care, treatment, and services provided.

a. Initial Pain Evaluation: Scale 0-10, NPASS, Faces pain scale, FLACC, Verbal descriptive, NIPS

b. The assessment should include a pain score and may include any of the following components based on setting, developmental age of the patient, diagnosis, and severity of the condition:

1. Pain intensity (Pain Score)
2. Location
3. Quality, patterns of radiation, character
4. Onset, duration, variations and patterns
5. Alleviating and aggravating factors

2. Pain should be re-assessed 30 minutes after an IV pain intervention, 60 minutes after oral intervention, and 30 minutes prior to discharge.

D. Blood glucose documented on any pediatric patient with a noted mental status change as reported by RN, MD or parent/guardian.

E. Physical Assessment:

1. Head to toe assessment

a. trauma patients
b. critically ill patient being admitted to an ICU

2. Primary assessment on all patients and soon as clinically possible.

3. Focused assessments based off of patient's chief complaint.

Example: Chief complaint of arm pain will include musculoskeletal, sensation, and peripheral vascular assessment.

F. Physical Reassessment:

1. The depth and frequency of the physical examination and functional pattern assessment is individualized according to the standards of care for the patient's population, patient's needs, patient's care plan, nursing judgment, and physician orders.

2. In the event that a critical change in status occurs, the frequency of assessment will be modified as necessary until stable or transfer to an appropriate level of care.

3. 30-60 minutes after intervention if not indicated sooner.

VI. RELATED INFORMATION

Table 2. Vitals signs (PALS)

AGE	HEART RATE	RESP RATE	SYSTOLIC BP	TEMP (C)
Term Neonate (0-28 days)	100-205	30-60	67-84	96.8-100.4
1-12 mo	100-180	30-53	72-104	96.8-101
1 yr – 3 yr	98-140	22-37	86-106	96.8-101
3 yr - 5 yr	80-120	20-28	89-112	96.8-101
5 yr – 12 yr	75-118	18-25	97-120	96.8-101
12 yr- 18 yr	60-100	12-20	110-131	96.8-101

VII. STATEMENTS

VIII. REFERENCES

Stone, Elizabeth. 2016. *Weighing All Patients in Kilograms*. Emergency Nurses Association Position Statement. https://media.emscimprovement.center/documents/Weighing_All_Patients_in_Kilograms_ENA_Position_Statement_Pzv9Nrx.pdf

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