

Peds/PICU Addendum

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Inpatient Pediatric Minimum Standards of Care

For additional information refer to full Policy: *Inpatient Pediatric Minimum Standards of Care* in PolicyStat

A registered nurse (RN) is accountable for performing a focused and comprehensive assessment, compliant with the Oregon State Board of Nursing (OSBN) Division 45 statutes, for patients < 18 years of age admitted to acute inpatient settings. The focused assessment and applicable screenings are determined by the reason for admission. From the time of admission, the following occurs:

- Focused assessment performed (within 4 hours)
- Plan of care initiated (within 4 hours), reviewed and updated whenever patient’s status changes
- Comprehensive plan of care established (within 8 hours)
- Comprehensive assessment and risk screening completed (within 24 hours) to:
 - Establish nursing diagnostic statements
 - Develop, implement, and evaluate care plans

These guidelines are intended for assumption of care, when a newly assigned RN assumes care for an assigned group or a specific patient, if providing 1:1 level care. Assumption of care can occur within a shift (e.g., census fluctuation) or between shifts. These guidelines exclude in-shift brief hand-overs done to provide meal or rest break support.

ADDENDUM C: Crosswalk for Assessments and Documentation Frequency [Copy Link](#)

ASSESSMENTS:	Admission	Assumption of Care	Q4H	Changes to patient condition	Q Shift	Hourly	QD	Q4Days	Discharge
Isolation Screening/Multi-drug resistant organisms	X								X
Epidemic Risk	X								
ROS	X								
Focused Assessment	X		X						
Comprehensive Assessment (head to toe)	X	X		X					
Prior to admission, meds, allergies, immunizations, and health history	X								
Wounds (*remove dressing to assess unless contraindicated)	X			X			X		
Skin Assessment	X	X		X	x				
IV site and fluid rate assess hourly for cont. infusions and q4 hours for saline locks - Documentation every 4 hours	X	X				X			
VS	X		X	X					

Inpatient Pediatric Minimum Standards of Care (Cont)

For additional information refer to full Policy: *Inpatient Pediatric Minimum Standards of Care* in PolicyStat

Check tubes and lines - Documentation every 4 hours	X	X				X			
Suicide Risk	X			X					
Complete Pain Assessment	X	X		X					X - Education
Sepsis	X			X					
Fall Risk Assessment	X	X		X	X				
Braden QD	X				X				
Nutrition Risk Assessment	X			X				X	

*Weight	X						X (under 30 days of age)		
Discharge needs	X								X
Functional activities & mobility	X			X					
Total I&O	X		X		X				
Screenings	Within 24 hours of admission Developmental within 4 hours or admission								
INTERVENTIONS:	Admission	Assumption of Care	Every 4 Hours	Every Shift of Care	Changes to patient condition	Each Patient Contact	PRN	Every 4 Days	Discharge
Familiarize patient to environment/ service	X				X		X		
Wound/skin care	As ordered								
Referrals based on order & admission screening data	X				X				
Individualized plan of care (Ensure to address fall prevention, pressure ulcer prevention, management of confusion, comfort promotion, etc.)	Developed within 4 hours		X	X	X				

Inpatient Pediatric Minimum Standards of Care (Cont)

For additional information refer to full Policy: *Inpatient Pediatric Minimum Standards of Care* in PolicyStat

Safe environment purposeful rounding, fall prevention interventions standard precautions, patient identification	X	X				X			
Monitor pertinent labs Document critical labs under LIP Notification in EHR	X	X			X				
Document CHEWS Alert under LIP Notification in EHR				X					

Safe Sleep/Newborn Falls

For additional information refer to full Policy: *Newborn Fall Prevention Practice Guidelines (Perinatal, Pediatrics, & NICU)* in PolicyStat

Provide education to mother and family on the following:

1. While in the hospital it is not permitted to sleep with newborn in the maternal bed or while sitting or lying on other furniture. Explain rationale and safety risk.
2. If they become sleepy, dizzy, or unsteady call for assistance to place newborn in crib/bassinet/isolette.
3. Inform parent/family if you find them asleep while holding their newborn, staff will transfer newborn to crib/bassinet/isolette.
4. Do not to leave newborn unattended on bed or couch.
5. Use of prescribed pain medications, increased blood loss, fatigue from labor and delivery, and bed positioning may increase risk mother will fall asleep and newborn will fall from hospital bed to the floor.
6. Leave bed in lowest position with side rails up during feedings.
7. If mother is using patient controlled analgesia, other sedating medications, or on seizure precautions she should have another responsible person for the newborn to remain in the room.

Keep sides of crib/bassinet/isolette in up position close to maternal hospital bed to promote closeness and attachment. Check on mother frequently when newborn is in maternal hospital bed.

All newborns must be transported in their cribs or bassinet lying flat with sides up or in an isolette. Newborn may be in mother's arms on stretcher and/or wheelchair if mother is stable.

Staff members to make safety assessments during all rounds and every time they enter room.

If parent/family declines to follow recommendations, document education and non-compliance in their electronic health record (EHR).

If a newborn fall does occur, call your lead nurse for support on the next steps and reporting.

Post-Fall Management:

Registered Nurse (RN) obtains vitals signs (VS), performs physical assessment, and notifies provider immediately of fall.

Physical assessment by newborn provider should be done as soon as possible and should include:

1. Full visible inspection for any evidence of trauma, with particular attention to the skull.
2. Neurologic assessment to include tone, alertness, movement.

Frequent observation of newborn is recommended for a minimum of 12-24 hours.

After initial assessment, vital signs and neuro assessment to include tone, responsiveness, reflexes, and fontanelle status or as ordered:

1. Every hour x 2
2. Every 4 hours x 2

After initial assessment, head circumference hourly x 4

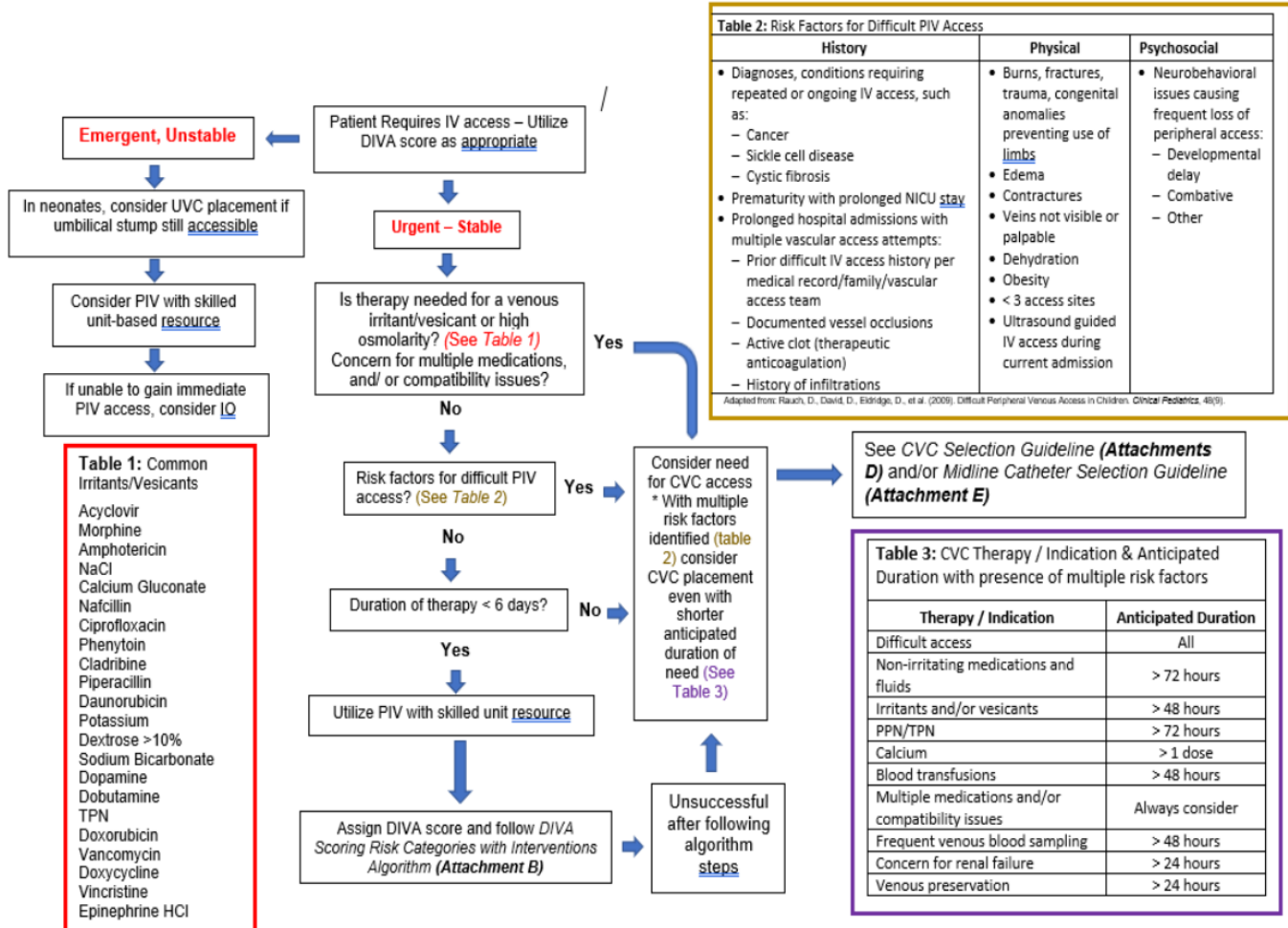
Pediatric provider should be immediately notified if any of the following occur:

1. VS abnormalities
2. Changes to behavior, movement, or neurologic status
3. New physical findings suggestive of injury
4. Vomiting
5. Any additional concerns

Establishing Peripheral Intravenous Access in Neonatal & Pediatric Patients

For additional information refer to full Policy: *Establishing Peripheral Intravenous Access in Neonatal & Pediatric Patients and PICC Policies: Peripherally Inserted Central Venous Catheters and Placement, Maintenance and Removal* in PolicyStat

Neonatal/Pediatric Vascular Access Algorithm



Newborn Glucose Management

For additional information refer to full Policy: *Newborn Glucose Management* in PolicyStat

NEONATAL HYPOGLYCEMIA PROTOCOL: SCREENING AND MANAGEMENT (≥35 WEEKS GESTATIONAL AGE)

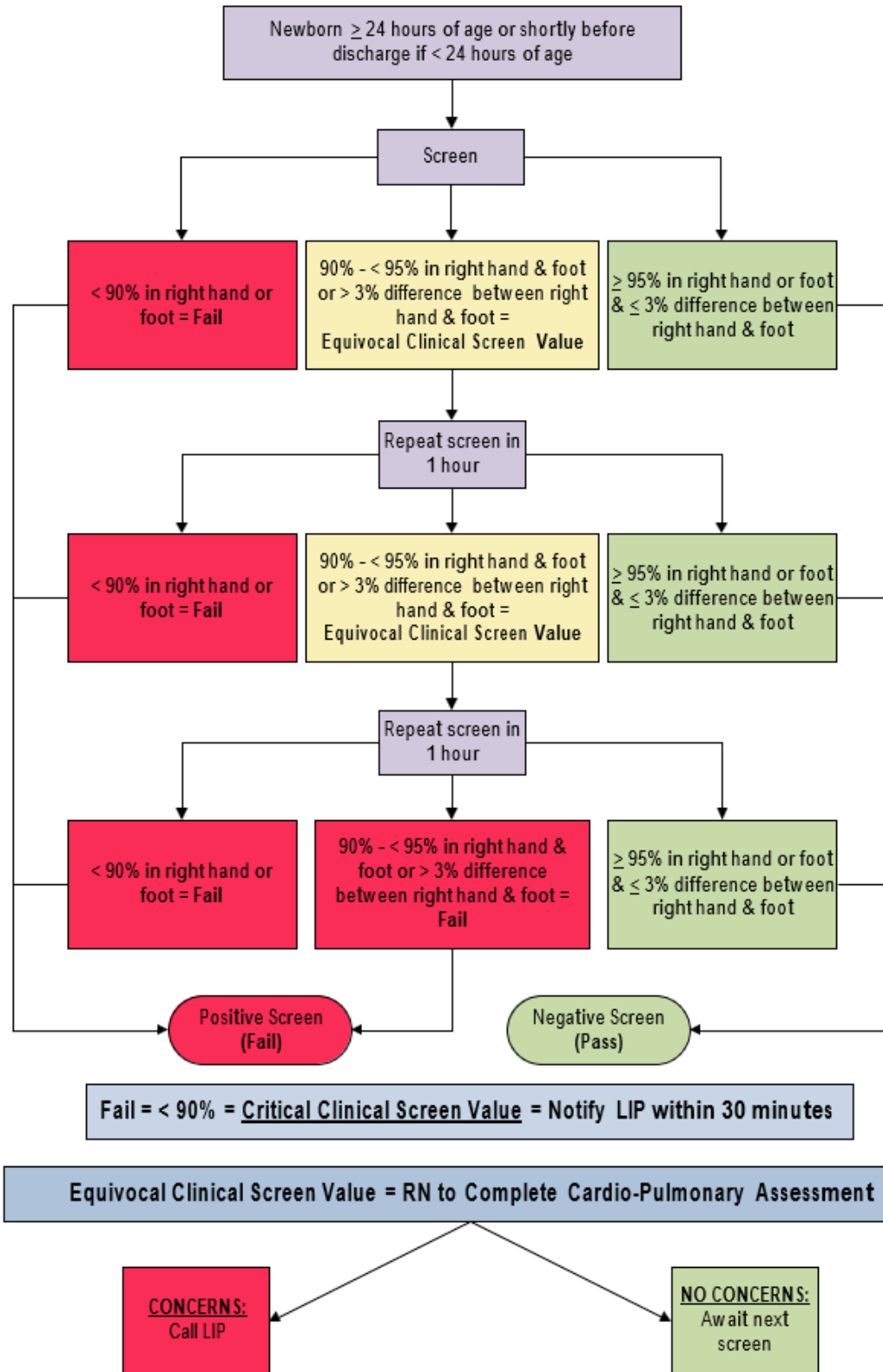
Initiate for any newborn with risk factors or symptoms

<p><u>RISK FACTORS</u></p> <ul style="list-style-type: none"> • LGA, SGA, or IUGR • Birth weight <2500 grams or >4500 grams • Infant of diabetic mother • < 37 weeks • APGAR < 6 at 5 min • Cord pH ≤7.0 • Suspected sepsis/symptomatic of sepsis 		<p><u>SYMPTOMS</u></p> <ul style="list-style-type: none"> • Jitteriness • Lethargy • Decreased muscle tone • Poor suck • Temp instability (≥38.0 or <36.4) • Irritability • High pitched cry • Respiratory distress • Pallor/diaphoresis • Seizures <p>SYMPTOMATIC NEWBORNS: Check glucose, treat per algorithm, & notify LIP for further management.</p>					
<p>Skin to skin ASAP after birth and breastfeed/feed within 60 minutes of birth. Check glucose level 30 minutes after completion of first feed or at 60 minutes of life if unable to feed.</p>							
<p>First CBG and up to 4 hours of Age</p>							
<p>Glucose ≥ 45 mg/dL</p> <ol style="list-style-type: none"> 1. Check CBG prior to each feeding 2. Feed at least every 3 hours and encourage skin to skin 		<p>Glucose 25-44 mg/dL</p> <ol style="list-style-type: none"> 1. Follow Treatment Plan 	<p>Glucose <25 mg/dL</p> <ol style="list-style-type: none"> 1. Notify LIP 2. Follow Treatment Plan 				
<p>All Subsequent CBGs ≥ 4 hours of Age</p>							
<p>Glucose ≥ 50 mg/dL</p> <ol style="list-style-type: none"> 1. Check CBG prior to each feeding 2. Feed at least every 3 hours and encourage skin to skin 3. Continue glucose monitoring until a total of 4 consecutive CBGs have been in the green zone 	<p>Glucose 45-49mg/dL</p> <ol style="list-style-type: none"> 1. If this is the first CBG in this range, feed and perform CBG prior to next feeding 2. If this is the second or more consecutive CBG in this range, proceed to Treatment Plan 	<p>Glucose 25-44 mg/dL</p> <ol style="list-style-type: none"> 1. Follow Treatment Plan 	<p>Glucose <25 mg/dL</p> <ol style="list-style-type: none"> 1. If this is the first occurrence in this range, notify LIP and follow Treatment Plan 2. If this is the second consecutive occurrence in this range: <ul style="list-style-type: none"> • Level I Nursery: Contact LIP to manage hypoglycemia, consider transfer if appropriate • Nursery with NICU: Contact LIP to transfer to NICU • NICU: Contact LIP to manage hypoglycemia 				
<p>Treatment Plan</p>							
<ol style="list-style-type: none"> 1. Glucose oral gel (40%) 0.5ml/kg PO massage into buccal mucosa 2. Immediately breastfeed AND supplement with EBM/DM or formula (NICU may gavage feed): <table border="1" style="margin-left: 40px;"> <tr> <td style="background-color: #fff2cc;">Yellow zone</td> <td>At least 5-10 mL</td> </tr> <tr> <td style="background-color: #f4cccc;">Red zone</td> <td>At least 10-15 mL</td> </tr> </table> 3. Recheck glucose level 1 hour after completion of gel and feeds and follow appropriate subsequent CBG column 4. Notify LIP after 2nd glucose oral gel dose is administered; LIP may consider repeating gel process up to max of 6 total doses of glucose gel <p><u>Level I Nursery:</u> At discretion of LIP, consider IV dextrose, consider transfer to NICU after 6 total glucose oral gel doses <u>Nursery with NICU:</u> Contact LIP to transfer to NICU after 6 total glucose oral gel doses <u>NICU:</u> Contact LIP to manage hypoglycemia after 6 total glucose oral gel doses</p>				Yellow zone	At least 5-10 mL	Red zone	At least 10-15 mL
Yellow zone	At least 5-10 mL						
Red zone	At least 10-15 mL						

Critical Congenital Heart Disease (CCHD) Screening

For additional information refer to full Policy: *Critical Congenital Heart Disease (CCHD) Screening for the Newborn (Perinatal, NICU, Pediatrics)* in PolicyStat

Critical Congenital Heart Disease Screening Algorithm



Weight-Based Emergency Medication Dosing for Pediatric Patients

For additional information refer to full Policy: *Weight-Based Emergency Medication Dosing for Pediatric Patients* in PolicyStat

Obtaining an Actual Weight in Kilograms:

- **Measure and document weight in kilograms only. Avoid using pounds as form of measurement and/or documented weight.**
- An actual weight in kg is taken upon arrival for care, including method used to correctly measure patients, and entered into patient's EHR following the *Entering Actual Weights in Kilograms during Pediatric ED Visits in Epic Cheat Sheet* (Attachment A). Acceptable methods include:
 - Standing
 - Infant scale or
 - Bed/crib scale
 - Broselow tape will be used for critically ill/injured patients where delaying care to obtain an actual scale weight or moving patient presents a negative risk to health outcomes. An actual weight in kilograms using an acceptable weight method will be obtained as quickly as clinically able to.
 - **NOTE:** Stated, estimated, or declined are unacceptable methods which should be avoided.
- Use appropriate scale for child. Weigh children less than 24 months without clothing or a diaper. Children over the age of 24 months may be weighed while wearing light clothing unless otherwise specified. Ideally the child should be weighed wearing only hospital gown or pajamas.
- Repeat measurements will follow *PSJH Universal Pediatric Guideline: Assessment, Care Planning, and Discharge* policy and as clinically indicated.

Identifying Broselow Cart Drawer Color Appropriate for Size and Age of Patient:

- **HEAD to RED:** Measure patient to determine weight/color zone when obtaining an actual weight in kg is not possible. If a patient appears overweight consider utilizing one zone higher for medication dosing only. Always use reference tape measured length zone for equipment selection regardless of body habitus.
- Place correlating drawer color sticker on patient's *Emergency Pediatric Dosing Sheet* and identification band.

Drawer Color	Weight Range	Age
Gray (located in shared pink/red drawer)	3-5 kg	<3 months
Pink (located in shared pink/red drawer)	6-7 kg	3-5 months
Red (located in shared pink/red drawer)	8-9 kg	6-11 months
Purple	10-11 kg	12-24 months
Yellow	12-14 kg	2 years
White	15-18 kg	3-4 years
Blue	19-23 kg	5-6 years
Orange	24-29 kg	7-9 years
Green	30-36 kg	10-11 years

Green drawer supplies may be appropriate for patients > 36kg and/or >11 years of age, but may require a transition to adult-sized emergency equipment and supplies not located in Broselow cart. Consult with licensed independent practitioner (LIP) to validate utilization of green drawer contents when a patient exceeds weight range and age limits listed above.

Documentation Requirements for Newborn, NICU and Pediatric RR and Code Blue Events

For additional information refer to full Policy: *Documentation Requirements for Newborn, NICU and Pediatric RR and Code Blue Events* in PolicyStat

Documentation Requirements Include:

A. During or After Event - At a minimum, EHR documentation will include start time, stop time, and end outcome included in:

1. *Rapid Response Flowsheet* for RRE or
2. *Code Narrator (Infant)* for CBE

B. Documentation not included in EHR is captured on a *Pediatric Rapid Response Patient Identification Form* (Attachment B) and scanned into patient's EHR for RREs.

C. Documentation not included in EHR may be captured on a *Pediatric/ Neonatal Code Blue* form (Attachment C or comparable ministry-specific form) and scanned into patient's EHR for CBEs.

Blood Product Administration in Pediatric Patients

For additional information refer to full Policy: *Blood Product Administration in Pediatric Patients* in PolicyStat

B. Blood Specimen Collection for Type and Screen:

1. Neonates to 4 months (day 120 of life):

- Do not need 2 type & screens
- For transfusion purposes, the initial type & screen is valid until age of four months (day 120 of life), since this is when naturally occurring ABO antibodies begin to appear.
- This "second specimen" policy doesn't apply to neonates because we always give universal donor RBCs & FFP to this population.
- NOTE:** If patient has been discharged since specimen collection for type & screen, then readmitted for further care, repeat specimen collection is required due to a change in the patient's identification arm band.

2. Infants >4 months:

- Need 2 type & screens

3. Specimen Volume:

- 1 mL is the minimum volume to run a type and screen.
- There is additional testing that must be incorporated into ABO type once a patient is >4 months.
- Volume could be filled either with two full pediatric specimen tubes or 1 mL in an adult-sized vacutainer tube.
- NOTE:** A historical blood type performed previously counts as the "second type." Blood bank techs make every effort to use either a historical type or a CBC (collected independently/at a separate time) from Type & Screen. If neither of these are available, they place an order for a second specimen to be collected. For these patients, the RN doesn't collect a second specimen unless directed by the Blood Bank.

C. Establishes and/or Verifies Vascular Access:

- 18-24 gauge intravenous (IV) catheter

B. Verify the Donor ABO on Blood Bag Label is Compatible with Patient ABO Listed on *Transfusion Slip Unit Tag*:

PRBC		FFP		Platelets & Cryoprecipitate
Patient	Unit	Patient	Unit	For patients >12: All patient and unit ABO groups and Rh types are compatible For patients ≤ 12: Follow compatibility chart for FFP For platelets, see table below
ABO Unknown	O only	ABO Unknown	AB only	
O	O Only	O	O, A, B, AB	
A	A, O	A	A, AB	
B	B, O	B	B, AB	
AB	AB, A, B, O	AB	AB Only	
Rh (+)	Rh (+) or (-)	Rh (+)	Rh (+) or (-)	
Rh (-)	Rh (-) (unless emergency)	Rh (-)	Rh (+) or (-)	
Rh Unknown	Rh (-): female ≤ 50 Rh (+): males or female >50	Rh Unknown	Rh (+) or (-)	

Blood Product Administration in Pediatric Patients (Cont)

Platelets for Patients 12 Years and Under	
Patient	Unit
ABO Unknown	AB Only
O	O, A, B, AB
A	A, AB
B	B, AB
AB	AB Only
Rh (+)	Rh (+) or Rh (-)
Rh (-)	Rh (-)
Rh Unknown	Rh (-)

The transfusionist will:

- A. Hang blood product for IV administration - following manufacturer's directions on blood tubing administration set preparation
 - 1. **NOTE:** 0.9% normal saline is only acceptable IV solution for use in transfusing blood components.
 - 2. **NOTE:** Do NOT add any medication to blood component.
 - 3. **NOTE:** Blood transfusions should be connected directly into venous access device and NOT piggybacked through other solutions. If quality of blood product is believed to have been compromised after initiating transfusion, stop transfusion and notify Blood Bank and LIP.
 - 4. **NOTE:** All blood administration sets should be changed every four hours. It is acceptable to use the same tubing for different or multiple blood components, provided the transfusion will be completed within the 4-hour time limit.
- B. Initiate transfusion slowly per LIP orders, while remaining with patient for at least first 15 minutes of infusion.
 - 1. **NOTE:** In emergent situations, the transfusion may proceed more rapidly.
- C. After initial 15 minutes, obtains VS. If no signs or symptoms of a transfusion reaction are present, increase to appropriate rate per LIP orders.
 - 1. **NOTE:** Some patients may require a reduction in IV fluid rate or administration of a diuretic to avoid volume overload.
- D. Continue to monitor VS every 30 minutes until transfusion complete

Completion of Transfusion:

- A. When transfusion is complete, document the following in EHR *Blood Administration Flow Sheet*:
 - 1. Full set of vital signs
 - 2. Total volume infused (in mL)
 - 3. Suspected reaction (choose "yes" or "no")
 - 4. Transfusion End time
- B. Flush IV site with 10 ml normal saline. For Neonates, flush line with a minimum volume to clear line.
- C. If patient has a central line, the end cap is to be replaced at the end of blood administration.
- D. Discard empty blood product bags in designated red biohazard bag.
- E. Return any un-infused blood products to the blood bank.

Naso-Oroenteric Tube Placement and Use in Pediatric Patients

For additional information refer to full Policy: *Naso-Oroenteric Tube Placement and Use in Pediatric Patients* and *POCT pH Neonatal Gastric Fluid pH test Paper Procedure* in PolicyStat

Insertion:

Refer to Lippincott *Nasogastric or orogastric tube insertion, pediatric* for details on equipment, tube insertion, and proper securement to avoid tube dislodgement.

Documentation:

Record the following in patient's electronic health record (EHR):

- Date and time of tube insertion
- Assessment findings
- Size and length of tube used
- External length measurement or incremental marking of tube and
- Verification method of tube placement used

Initial Verification of Correct Tube Placement (Prior to Administration of Medications, Fluids, or Nutrition):

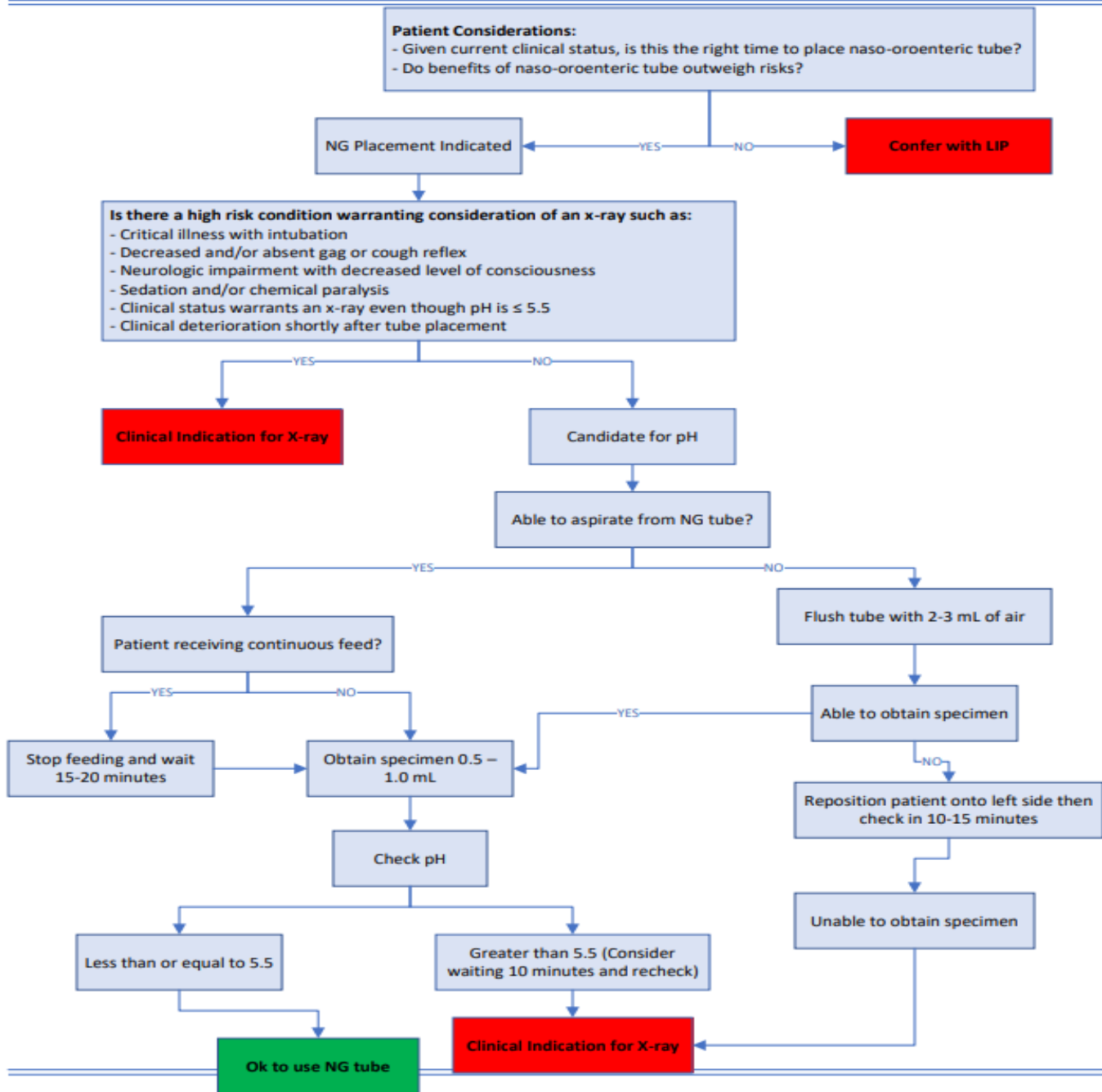
Following the *Naso-Oroenteric Tube Placement & Verification Decision Tree* (Attachment A), perform:

- pH measurement of gastric contents confirming tube is in an acidic environment and/or
- Abdominal radiograph to visualize tube ending is in the stomach/intestinal tract

Perform a minimum of one secondary bedside verification method, which may include:

- Watching for signs of respiratory distress, such as coughing and dyspnea, which indicate improper tube placement
- Using capnography (if available) to detect carbon dioxide, which indicates inadvertent tracheal insertion
- Aspirating secretions from tube with an enteral catheter-tip syringe and inspect visual characteristics of the aspirate:
 - Fasting gastric secretions commonly appear grassy-green, brown, or clear and colorless
 - Aspirate from pleural space typically has a pale yellow, serous appearance
- Validating measurement of external tube length to determine if tube has moved after placement:
 - For tubes with incremental measurement marks: Observe and document measurement noted at tube exit site (nare or mouth)
 - For tubes without incremental measurement marks: Measure and document tube length from tube exit site to connection port on external end of tube

Naso-Oroenteric Tube Placement & Verification Decision Tree



Heated Humidified High Flow Nasal Canula Use for Pediatric Patients

For additional information refer to full Policy: *Heated Humidified High Flow Nasal Canula Use for Pediatric Patients* in PolicyStat

- A. Patients on HHHFNC may have an initial flow rate per LIP order inclusive of specified flow and O2 saturation range as follows:

1.	Weight	Flow Rate
	Up to 12 kg	2L/kg/min
	13-15 kg	30 L/min
	16-30 kg	35 L/min
	31-50 kg	40 L/min
	> 50 kg	50 L/min

2. Start FiO2 on blender at 100%

3. Patients < 44 weeks PMA (corrected for gestational age) include NICU and/or PICU LIP consultation.

- B. Stable patients may remain on IPPED while on HHHFNC flow rate at 2L/kg/min as defined by:

1. Maintaining or improving VS
2. Maintaining or improving CHEWS score and
3. Tolerating specified flow and O2 saturation range ordered by LIP

- C. LIP/Charge RN/PICU Intensivist notification are required for the following:

1. All patients on HHHFNC flow rate > 1L/kg/min, including any additional increase in flow rate
2. Previously stabilized patients with FiO2 requirements increasing > 50%
3. Patients on HHHFNC at 50L/minute maximum

- D. Patients remain NPO while maintained on HHHFNC flow rate of 2L/kg/min

- E. Maintain PIV access

PICU-Minimum Standards of Care

For additional information refer to full Policy: *PICU-Minimum Standards of Care* in PolicyStat

Charting Element	Frequency of Activity	Comments
Admission	<ul style="list-style-type: none">*Completion of head to toe assessment within 1 hour of admission.*Weight (taken in kilograms) documented within 15 minutes of admission for the purpose of calculating patient emergency medication sheet.*Height*Allergies (including latex sensitivity)*Completion of full admission (see comment box) documented within 4 hours of admission	<ul style="list-style-type: none">*Full Admission documentation to include:<ul style="list-style-type: none">• Screening for immunizations, suicide and sepsis• Safety assessment (if patient >8, should be completed without the parents present)• Allergies and latex sensitivity• Prior to admission medications initiate plan of care (Select ≥1 CPG reflecting reason for admission)• Fall risk• Braden QD Scale• Nutrition risk• Patient belongings• 4-eyes skin assessment

Document ***every 1-2 hours*** based on patient orders:

- Vital signs (T, HR, RR, BP, SPO2)
- Pain
- Hemodynamics
- Comprehensive head-to-toe assessment
 - Neuro
 - OFC (if under 24 months)
 - Fontanelle (if under a year)
 - LOC
 - Pupils
 - Grip strength
 - Movement of extremities
 - GCS
 - Seizure precautions
 - Respiratory
 - Airway patency
 - Tube placement/securement
 - Secretions
 - Breathing (effort, auscultated breath sounds)

- Cardiac
 - Auscultate apical rate/tones
 - Pulses, cap refill, turgor, edema, patient color
- Gastrointestinal
 - Abdominal size, shape, tension
 - Auscultate bowel tones
 - appetite
- Intake/Output (Quality and quantity)
 - including IV fluid/medication admin
 - Urine/stool/emesis
 - Blood (blood draws and waste)
 - NGT drainage

Document **every 2 hours** based on patient orders:

- ADLs

Document **once per shift**:

- Bundles
 - VAP prevention
 - CAUTI prevention
 - catheter care
 - Sepsis screening

Document **daily**:

- Weights
- CHG bathing for patients with central lines/indwelling catheters