1.0 Purpose
To minimise admission stress on paediatric patients and their parents/carers.

2.0 Scope
All paediatric admissions.

3.0 References

4.0 Definitions

5.0 Procedure
Rationale
A planned systematic approach is used to provide patient centred care, specific to the needs of the paediatric patient. Only children over 2 years will be admitted to The Surgery Centre.

Policy
Parents or the next of kin will have ready access to their child at all times, except during surgery.

Children will be admitted in age sequence, with the youngest child being operated on first, unless co-morbidity patients require priority.

Accredited paediatricians, anaesthetists, surgeons and pathology services will be available 24 hours a day when there is a child in the hospital.

Registered Nurses with post-basic or post-graduate paediatric experience will be on duty at all times whilst a child is a patient in the hospital.

Specialty surgery for children at The Surgery Centre will be:
Dental, Urological, ENT & General surgical procedures

There will be a maximum of five children accommodated at any one time. The average length of stay will vary with the nature of the surgery and treatment provided. On average this will be 1-3 days. This does not apply to children who are undergoing Day Surgery procedures.

In general, the hospital will restrict paediatric admissions to healthy children who are low risk patients with no co-morbidities.
Admission procedure

It is beneficial for children and parents to visit the unit prior to the day of admission, a familiarisation tour is given, and anxiety allayed.

The admission process is carried out in the nurse consulting room. Weight, temperature, and pulse are recorded; allergy and fasting status are also checked and recorded.

Children are encouraged to bring a favourite toy, and may be accompanied by both parents if desired. It is requested that other children in the family not be brought to the unit. Parents are requested to bring their children in either pyjamas or comfortable loose fitting clothes.

One parent/carer may accompany the child into the operating room and remain with the child until induction. The parent/carer will then be escorted back to the waiting room by one of the operating room staff. Parents accompanying children into the operating room will be required to wear a gown, cap and overshoes over their clothes, and must always be escorted by a staff member as per ACORN Standards S11 & S24.

Emla cream will be applied to all children from the age of 2 years unless directed alternatively by anaesthetist. As the cream requires at least 60 minutes to be effective it must be liberally applied over a vein and covered with an occlusive dressing (Tegaderm).

The anaesthetist will assess each child prior to going into operating room and discuss the option of the parent going into operating room to be with the child during induction. This is at the discretion of the anaesthetist; however no parent should feel compelled to go into the operating room against his or her wishes.

On occasions the anaesthetist may prescribe a premedication. This usually consists of Midazolam or Panadol or both.

PROCEDURE

Baseline observations must be recorded on admission:
- Temp
- Pulse
- Resp
- Pulse oximetry
- Blood pressure is not attended unless specifically requested by medical officer.

The child’s weight must be recorded in the Clinical Information System (Anaesthetic Chart & Medication Chart).

Fasting Protocol
Up to 2 hours pre-op.
- Water
- Cordial
- Apple juice
N.B. fruit juice with pulp, such as orange juice or apricot nectar is not suitable.

**Up to 3 hours pre-op.**
- Breast milk

**Up to 4 hours pre-op.**
- Formula
- Plain milk

**Up to 5 hours pre-op**
- Toast (not whole grain)
- Cereal

**Clothing protocol for parents accompanying the child into operating room**

Parents are to wear a gown, cap and overshoes over their clothes and wear a face mask (as required) if escorting child into theatre.

To help allay the child's anxiety, dress the parent in the nurse consulting room in the presence of the child.

**Parents in operating room**

Only one parent may accompany the child.

The parent sits or stands with the child as directed by the anaesthetist. If sitting and holding a smaller child the parent is to be seated on a stool with non-moveable wheels.

Two nurses are to be in attendance at this time, one is to assist the anaesthetist; the other is to escort the parent from the operating room at the completion of induction. The parent is to return to the waiting room and instructed to remove the gown, it is often at this time the parent becomes tearful and may need reassurance.

**Admission to Recovery**

When preparing the Recovery Room for a child, staff must enquire about the child’s age to ensure all equipment is age appropriate and any special requests by the Surgeon and Anaesthetist can be met. Adult equipment may be moved if not required.

Post-surgery the child is to be transported to recovery with the anaesthetist and one other person. In First Stage Recovery the staff/patient ratio must be 1:1 at all times.

Recovery staff must wait until the child regains consciousness before requesting presence of the parent/carer. Once the child is conscious it is accepted practice to allow them to be
nursed by the parent/carer providing they remain in reach of emergency equipment, however this is at the discretion of recovery staff.

**Management & Observational Assessments**

**Airway Management**

Unless otherwise ordered, all children should have 6 litres of oxygen via circuit / facemask. This will minimise rebreathing of CO2 and avoid diffusion hypoxia

Children should be placed in the coma position unless contraindicated, to aid drainage of secretions from the oropharynx.

A Guedel airway, if in situ, should be removed once the child has awakened and is able to maintain an open airway.

**Routine Observations**

A minimum of 10 minutely observations of colour, heart rate, chest movement, respirations and blood pressure (when ordered) should be taken.

Care must be taken to maintain body heat particularly for young children and infants.

As children do not always comply with pulse oximetry and monitoring, astute observation of the child is required.

Children <5 yrs should have the apical heart rate recorded and in children >5 yrs palpate brachial/femoral pulses. Carotid pulses should not be attempted on an infant due to neck size.

**Intravenous Therapy & Medications**

Two registered nurses or one RN and one Endorsed Enrolled Nurse are to double check and sign for all oral, IV, IMI, SC, PR, nebulized drugs.

The drug calculation will be based on the child’s weight must be checked independently by the two registered nurses.

The two registered nurses must check:

- The patient’s weight
- The correct patient
- The correct dose
- The correct route
- The correct time
- The correct drug

If there are any doubts as to the ordered dose or to the calculation of the medication a medical officer must be contacted immediately.

IV cannula’s must be secured and left insitu while in Recovery and remain insitu until the child is admitted on the ward or moved to the stage 2 recovery lounge.
Cannula site is checked hourly for redness, swelling, tracking and pain. Where IV access is lost or shows signs of redness, swelling, tracking or pain, the Anaesthetist must be immediately notified.

All IV fluids for children are to be administered with a burette attached to the giving set and must be administered via an infusion pump.

Children may start oral fluids in Recovery on instruction from the Anaesthetist.

**Pain Management**

Staff must ensure adequate analgesia has been ordered for Recovery and return to the ward.

There must be a copy of the following references in Recovery:
- Pain Management Policy (refer Paediatric narcotic dilutions)
- A Paediatric Pharmacopoeia for correct dosages

The Anaesthetist must be notified of any child who receives an IV/SC narcotic in Recovery as they may be required to remain in First Stage Recovery for an extended period of time.

**Transfer to Ward**

Length of stay in recovery should be determined by the child’s level of consciousness and their normalisation to baseline observations.

A child may be transferred to the ward or discharge lounge once;
  • vital signs are within normal limits for the patient (confirm baseline observations)
  • is easily rousable and has an intact protective airway reflex
  • can talk if developmentally appropriate.

Any child who does not meet the above criteria must be reviewed by the attending anaesthetist prior to ward transfer or discharge.

Suggested length of stay in 1st Stage Recovery for paediatrics is as follows:
- 20 minutes following narcotic administration
- if the patient is in pain, vomiting, bleeding or in any way distressed they must remain in Recovery until the problem/s are addressed by a MO.

Parent or next of kin will be allowed to stay overnight with their child in the ward suites. Sleeping accommodation is provided using the single pull out lounge/bed which is located in each patient room.

**6.0 Records**

Patient file – Clinical Information System.

QP7515F1A Operation notes – Anaesthetic

QP7511F1 Activities Record

QP7511F2 Admission Protocol Checklist