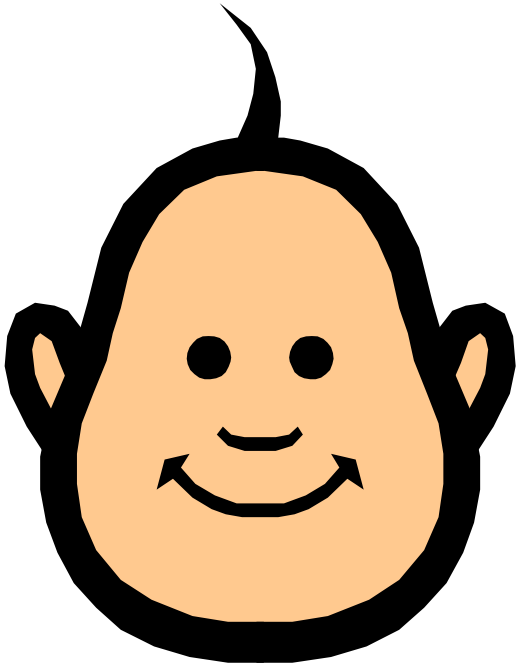
2 SOUTH

ORIENTATION PACKAGE



Updated on 19/01/2014

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Welcome to the Paediatric and Adolescent Unit!

Because Paediatrics is a specialised area which may be unfamiliar to you, we have created an orientation programme that aims to assist your adjustment to the ward and integration into our nursing team.

Our ward staff will be a valuable resource to you and are available to advise, assist, answer questions or direct you where needed. Self motivation and involvement is essential. What you gain from your time with the Paediatric Unit very much depends on what you are prepared to put in.

INTRODUCTION TO NURSING AND MEDICAL STAFF

Nurse Unit Manager (NUM)	***Registered Nurse: Div 1 & Div 2***	***Paediatricians***
Associate Nurse Unit Managers (ANUM)	***Ward Clerk***	***Registrars***
Clinical Nurse Specialists (CNS)	***Ward Assistant***	***Residents***

All members of staff work in collaboration towards a similar goal, that is, to care for paediatric patients, their families and/or care givers.

Members of the Nursing staff, Paediatricians and Allied Health Professionals work as a team to assess, monitor and educate patients and their families.

Paediatricians: In order of most senior to most junior:
- Consultants / Locums
- Registrars
- Residents / Intern / HMO
- Paediatric Registrar & Resident (alternating)

A list of the current medical officers is located on the desk under the white board.

STRUCTURE AND ADMINISTRATION OF THE PAEDIATRIC & ADOLESCENT UNIT

Handover:
Takes place at the beginning of each shift. Handover is usually delivered by the nurse in charge of the shift.

Patient Allocations:
Allocations are made by the nurse in charge following handover and are posted on the "patient whiteboard" in the nurse station.

Paediatric Round: *Mondays at 0900 and Thursday at 0900 hours*

Present: Nurse Unit Manager
Associate Nurse Unit Manager
Nurse caring for patient
Medical & Nursing students
Paediatricians
Registrar & Resident
Allied Health Professionals: Social Worker & Dietician

Meal Breaks:
Morning & Afternoon Tea: 15 min
Lunch & Dinner: 30 min

Your allocated meal break will be written on the Daily Planner whiteboard next to the photocopier. Please notify the nurse in charge if this time is not suitable.

Observations:
- Most patients unless otherwise indicated have regular observations 4/24 of temp, B.P, pulse & resps
- (0400, 0800, 1200, 1600, 2000, 2400)

- A BP should be done on admission for a baseline and continued on pt's that do not get distressed or that is medically indicated.
- If the pt is on oxygen they should be on hourly obs of SpO2, HR, Respiratory Assessment & 4/24 Temp.
- Patient's being treated for gastroenteritis should be weighed 6-8/24. If patient is weighed wearing clothing, then the type of clothing must be documented and remain consistent for each weigh. In infants, toddlers and young children, naked weights are the most accurate method of determining fluctuations in fluid status.

Paging System:

LAN Page on Computer write a short message and leave a contact number and name. (see the paging protocol on the wall at main nurses desk)

Education:

- Watch the notice board or Intranet and Daily Planner
- All staff are encouraged to participate in education
- Mandatory education is in the Daily Roster folder.
- Any staff member attending a study day must present knowledge gained (please allocate day as soon as possible after the study day on either a Monday / Tuesday).
- A number of competencies must be achieved annually. Education sessions will be held regularly in the Education Resource Centre (ERC).
- Each staff member is required to participate in a portfolio. Please discuss this with the NUM.

Ward Meetings:

- Notification and Agenda posted in write up room, please add any concerns or suggested agenda items
- Please read minutes if not present at meeting. These will be on the S drive.
- Participation is greatly encouraged.

Rostering & Time Sheets:

- Nursing rosters are found in the folder kept in the cubby hole beside the x-ray films in the nurse station.
- All roster requests to be put through 'One Staff' **OR** on the request sheets in the Roster folder (if requesting in the folder red = preferred/must have otherwise write in pencil or blue/black pen).
- Any changes to requests post closing date must be made directly to person doing roster
- Please try to be flexible when making requests where possible.
- Time sheets can be found in a folder also kept in this location and are sent to Pay Office the Thursday prior to your pay date. Ensure you have filled in and signed your payslip prior to this date to ensure accurate pay.

Annual Leave Roster:

- In Roster folder. (Note the EFT permitted when applying for annual leave)
- Please be aware of limited booking times, eg. December/January or June/July.
- Forms need to be completed and forwarded to NUM for approval (Forms available in time sheet folder or on the intranet).

Email: All staff should have an email address at BHS. If you require help to set up, contact the IT department.

Locker:
- If there is a free locker available you may use it for the duration of your shift.
- If the locker is not available you can lock you bag etc. in the cupboard underneath the TV (key located on the Handover room keys).

Patient's meals:
- Main meals, such as Breakfast, Lunch & Dinner will be given out by Environmental Services Staff.
- Snacks such as Morning Tea & Afternoon Tea can be given out by nursing staff with snacks available from the ward kitchen. If there are no snacks available, please contact the kitchen to order more.
- Patient's requiring special diet (e.g. Diabetic / Anorexic) will have their meal kept in the ward kitchen as their meal times may not co-relate with normal ward meal times. Their meal times will be documented on the white board in the kitchen. Please check that the meal has arrived and is correct and cold.
- Day stay theatre patients will have their meals ordered on admission and kept in the ward kitchen for nursing staff to provide once they are able to drink and eat post surgery.

Staff parking:
- It is anticipated that works will begin on the new Multi Storey Car Park/Helipad on Monday 13th January, 2014 resulting in closure of the current car park for a 12 month period.
- Limited short term parking will be available on site during construction.
- During this time, staff are asked to park in alternative locations, which include Eureka Linen, the City Oval and Drummond Street North (Macarthur Street end).
- Shuttle buses are available to assist staff in the returning to their vehicles. For more details on the bus schedule please see a staff member on the ward.

SAFETY

There are multiple safety issues on 2 South. Please make yourself aware of the following:
- Cot sides: must be up at all times when the child is unattended.
- Baths: Under no circumstances is a child to be left unattended.
- Baby Baths: To be filled from the nearest tap with bath resting in frame at all times.
- Prams: A child is not to be left unattended or left sleeping in the pram.
- High chairs: The child must be strapped in at all times and not to be left unattended.
- Hot food/drinks: Can be brought in by the carer however, drinks must have a lid and no food or drink can be given to any child who is fasting or to any other patient within the unit.
- Nappy bin: All soiled nappies must be placed into a nappy bag and disposed into the green bin located in the corridor.
- Clean around bed side: The area must be left clean and tidy at all times to allow for access.
- Parents are not to attend to any child not under their care.
- Doors security/video surveillance: Can be locked in situations that are needed and swipe cards to be used for access in locked doors. Exit areas are under constant video surveillance.
- Supervise in play room: All siblings must be supervised by their carer, it is not the responsibility of nurses.
- Hot water jugs: Used for warming up bottles and are to be left in formula room at all times.
-

'WHERE TO FIND WHAT' SEARCH

Additive Labels x 2		*Identification Labels*	
Arm Splints		*Intravenous Equipment:*	
Angel Cream/ Emla		*- IV Fluids*	
Apnoea Monitors		*- Giving Sets*	
Auriscope		*- IV Burettes*	
Baby bottles & teats		*- IV Poles*	
Bandages		*Linen bags & skips*	
Bed signs		*Milk formulas & Sterile Water*	
Blood tubes		*Medication info (MIMS, pharmacopoeia etc)*	
Blood pressure cuffs		*Neopuff*	
Blood Pressure sphygmomanometer (portable)		*Night lights & torches*	
Breakfast cereals		*Organisational & ward information folders*	
Charts (i.e. Nursing note, FBC etc)		*Oxygen & suction roll down kits*	
Creams & ointments		Oxygen Meters: Normal, low and low low	
Dressings, Band-Aids, Steristrips, Tegaderm etc.		*Parent accommodation & pantry*	
DVD's, Video's & Games		*Paediatric urine bag*	
Fire Exits		*Resus Trolley*	
Fire Extinguishers		*Request Slips*	
Glucometer		*Scales (chair and baby)*	
High Chairs & Prams		*Spacers*	
Histories (past & present)		*Specimen containers*	
Humidifiers:		*Stethoscopes*	
- Bases		*Stickers*	
- Circuits		*Toiletries (Soap, Shampoo, Toothbrushes)*	
- Intra-Nasal Canulas		*Tympanic/Axilla sure temp*	
- Masks		*Urine testing equipment*	

PAEDIATRIC AND ADOLESCENT NURSING HISTORY GUIDELINES

PAEDIATRIC ADMISSION / DISCHARGE CAREPLAN

Care plan to be completed on all patients on the day of admission except those who are termed as *day stay*.

THIS IS A LEGAL DOCUMENT. It is an expectation that when the care plan is maintained, i.e. signed by the person looking after the patient, it is unnecessary to further document the provision of this care. If there is insufficient space to make a change, start on the next column.

N.B. ***It is an expectation that parents will be informed and involved in treatment, progress and changes in care. It is also expected that explanations and support be provided to parents and patient whenever appropriate.***

SECTION 1

I.D. / Allergy Bands:

- Ensure that you check that the child has an identification band. If the child has an allergy band ensure the band is red. This identifies the child has an allergy and prompts staff to question what they are allergic to. The type of allergy must be documented in the admission notes and on the drug chart. It may also be relevant to place a sign above the child's bed stating any food/skin allergies to alert kitchen staff. If the child is mobile and cannot speak for themselves, pin a sign on to the child's clothing.

General History

- State the parent's names & who the legal guardian is.
- If there are custody/court orders in place, a photocopy of the order should be placed in the patient's history.
- State who the patient will be discharge to & their destination.

Present Medical/Surgical History:

- Details of symptoms during lead-up to admission.
- Why the child has been admitted. Child / parent opinion.

Relevant past History/Operations:

- Has the child had the same or similar illnesses in the past.
- Any operations in the past.
- Any problems with anaesthetics (if having surgery)
- Is child up-to-date with immunizations.
- Any past history, e.g. asthma (last hospital admission, if any), epilepsy, heart conditions, blood disorders, kidney disease. Include any other health problems which appear relevant to this admission.
- Has child had *'normal'* development. Assess by observing child's milestones for age.
- Any idiosyncrasies that the child may have, e.g. security blanket, favourite toys, whether sleeps any particular way, any activities the child may do out of the norm.

Present Medications:
- Is the child on any medications at home (e.g. asthma puffers, contraceptive pill, panadol etc).
- If so, how often taken, what for and when was last taken.
- Whether child has been on anything in the past relevant to this admission.

Immunisation Status:
- Is the Child up-to-date, offered immunisation or received immunisations during their admission.

Child Health Care Record:
- Has it been sited Yes/No

Elimination / Continence:
- Is the patient continent, wear nappies or have any problems with elimination.
- Do they require any form of management.

Allergies:
- Whether drug, food, skin etc. If so, what the parent uses to compensate for the allergy.
- What the reaction actually is, e.g. rash, swelling, vomiting etc.
  (consider if these symptoms indicate true allergy or medication side effect e.g. Penicillin = loose stools)
- Apply a red identification band.

SECTION 2

Infant Feeding:
- Whether the child is breast fed or bottle fed.
- What type of formula / beverage child has in bottle / cup.
- How much child has in bottles, and frequency of feeds.
- What type of teat child has on bottle and type of dummy (if has one).
- Whether child has a feeding cup, cup with a straw, or drinks freely from a normal cup.
- Whether child feeds themselves or is spoon fed.

Normal Eating Pattern:
- (Only if child cannot vocalise needs).
- What the child normally eats at home.
- How child usually has meal presented to them: mashed, cut-up, prefers finger food.
- Meal times (if different from normal).

Preferred Fluids:
- Inform parents that we provide cordial, orange juice, milk (flavoured), tea, coffee and some formulas.
- Encourage parents to bring any other fluids the child would like.

SECTION 3

Overall Appearance:
- How does the child present to you, e.g. lethargic, happy, quiet, shy, distressed, flat, aggressive, anxious, restless, content etc.
- Any evidence of pain.
- Hygiene / grooming.

Observations:
- *Height:* All babies less than 12 months of age (measure on change table) & all medical patients.
- *Weight:* All patients are weighed on admission.
- *Head Circumference:* All babies under 12 months of age, and others where indicated e.g. increased intracranial pressure
- *Oxygen Saturation:* All patients with heart condition, respiratory problems, or under 12 months and going to theatre for surgery.
- All other vital signs are noted on MR/605.1

Skin:
- *Turgor:* Refers to the amount of elasticity in the skin, indicating hydration status. Use tips of fingers to pinch up a fold of skin. Normal skin quickly falls back, dehydrated skin remains in the pinched position, or slowly releases back.
- *Abnormalities:*
  1. Colour: pallor, cyanosis, redness, jaundice, flushed, petechiae. Area involved (draw on chart).
  2. Pigmentation: any marks or scars that is suggestive of healed injuries,
     e.g. cradle cap, nappy rash, excessive dryness, bruises, scratch marks, wounds, insect bites, birthmarks, any body rash, eczema, operation scars.

Respiratory:
- *Chest Shape:* Is symmetrical or other (barrel chest).
- *Movement:* Observe for normal inspiration and expiration. Note intercostal retraction, decreased movement on one side, any asymmetry of movement. Any pain with breathing.
- *Coughs:* Determine presence of coughs - dry, moist, irritating, any colour change with cough, paroxysmal, length of coughing bout.
- *Noises:* Fine crackling sounds, coarse crackles, loud bubbly gurgling sounds, wheezing, creps, grunting or stridor. State whether there is good air entry into lungs or if there is any area that may be compromised. (For more detailed information Re: Respiratory Assessment, see Paediatric Respiratory Learning Package)

Abdominal:
- *Shape:* Prominent, flat, obese, concave abdomen, acities, bloating.
- *Skin Condition:* Wrinkled, creased, stretch marks, wasting.
- *Movement:* Bowel sounds, peristalsis, abdominal breathing, tender, lax.
- *Umbilicus:* Observe for cleanliness, herniation & discharge.
- *Palpation:* Hard/Firm, Soft/Lax, Rebound tenderness, generalised discomfort on palpation.

Skeletal:

- *Head / Neck:* Observe the face for symmetry, shape deformity, range of movement.
  Observe for head control in infants, head posture in older children.
  Observe for any neck stiffness, pain.
  In infants - palpate the skull for fontanelle - the anterior fontanelle normally closes between 4 and 26 months. 90% close between 7 and 19 months. The posterior fontanelle usually closes by 2 months of age.
  Note for bulging, fullness in anterior fontanelle, indicating increased intra-cranial pressure.

- *Limbs:* Observe each extremity for symmetry of length and size.
  Note any extra digits, or fusion of digits.
  Note temperature of limbs, swelling, redness, tenderness, parasthesia, masses, bow legs, knock knees, range of limb motion, and extent of mobility.
  Inspect feet for any deformities/sores etc.
- *Back:* Note abnormalities - curvature of the spine, lordosis, kyphosis.
  Note any hair tufts, dimples, dislocation, swelling, tenderness.

Circulatory:

- *Nails:* Should be pink, convex in shape, any variations could be that they are blue/yellow in colour.
- *Mouth:* Observe lips for colour, painful, inflamed or dry, cracked, herpes. Observe gums for swelling, bleeding, and ulcers. Observe tongue for colour, movement or drooling. Observe general colour of patient, temperature by touch.
- *Capillary refill:* Refill should be <3 seconds to all extremities and central sternum.
- *Peripheries:* Skin temperature of extremities should be equal to torso.

Genitourinary:

- Check when appropriate for any problems, physical abnormalities, any difficulties with voiding, hypospadias, rash, swelling, discharge.
- State on admission whether a paediatric urine bag is currently insitue or needs to be applied.
- When ever medically indicated children should have a urine full ward test done e.g. Fever FI, abdo pain, diabetes, constipation, abdo trauma etc.

Neurological:

- State if the child is alert, drowsy, responsive to verbal/painful stimuli, pupil reactions, orientated, rouseable.
- If the patient presents with a past history of any congenital abnormalities,
  e.g. cerebral palsy, Down Syndrome etc.
- State the extent of the syndrome and any ways in which the parents deal with care and ADL's.

Discharge Planning:

- To determine the parents ability to care for the child on discharge by asking the parent 5 yes/no questions.
- If yes is the response to any of these questions, give details in the space provided in *section 4*.

Ongoing / New Community Services:
- To identify if there are any community services currently involved with the patient.
- Does the community service need to be notified of admission.
- If you identify any community services that will be required on discharge such as HITH it is ideal to notify them 2 days pre-discharge if possible

Discharge Plan discussed with patient / carer:
- Ensuring patient carer is involved in planning of discharge

Discharge Information:
- Checklist to ensure all areas are covered prior to discharge.
- Please ensure all sections of the nursing history are completed. If things are not relevant to the particular child, please state *'not applicable'*. If for some reason the physical examination is not completed on admission, please state this so that it can be done when possible.
- If parents or guardians are not present on admission, write this at the top of the front page and hand over to staff coming on to the next shift so that they can follow this up when parents or guardians come in.
- Any relevant history should be presented at handover to the next shift, so they are aware of any problems.

We hope that you find this nursing history easy to follow, and comprehensive.
If you have any questions, please ask

WARD PAPER WORK

These charts are self explanatory. Take time to peruse them and familiarise yourself with them:
- Short Stay Anaesthetic Form
- Paediatric Nursing History / Discharge Form & Care Plan
- Paediatric Fluid Balance & Observation (Note correct age to form)
- Same Day Theatre Menu
- Pre-Op Check List
- Pathology Report Forms
- Bed Cards / History Spine Slips

COMMON PATIENT CONDITIONS FOUND ON 2 SOUTH

Below is a list of <u>some</u> of the common patient conditions found on 2 South. Having a basic understanding of these conditions will assist you with your care of your patients.

Asthma		Cerebral palsy		Myringoplasty	
Abscess		**Diabetes (DKA, newly Dx)**		Nephrotic Syndrome	
Anaphylaxis		**Eczema**		Osteomyelitis	
Arthroscopy		**Epilepsy**		**Pneumonia**	
Appendicitis		Failure to Thrive		Pyelonephritis	
Autism		**Febrile convulsion**		**Seizures**	

BSM		Febrile Neutropenia		Sepsis	
Bowel obstruction		Feeding problems		Septic arthritis	
Bronchiolitis		**Fractures**		Septoplasty	
Burns		**Gastro/ dehydration**		**Teeth extractions/Fillings**	
Candidiasis		Head Injury		**Tonsillectomy/Adenoidectomy**	
Circumcisions		Hernia		Quinsy	
Cellulitus		Hypospadius Repair		**URTI**	
Croup		Meningitis		UTI	

Information is readily available:

- Staff members will be more than willing to answer questions.
- The ward has reference texts which are located in the handover room and write-up room.
- Educational videos, located in Video Cupboard, please return when finished.
- Parent Information Sheets, located in a folder on the nurses desk or on the intranet.
- Hospital Library
- Internet (i.e. RCH website)
- Intranet

PERIPHERAL INTRAVENOUS (IV) DEVICE MANAGEMENT

Peripheral IV devices are cannula's that are inserted into a small peripheral vein for therapeutic purposes such as administration of medications, fluids and/or blood products.

Peripherally Inserted Central Catheter devices (PICC or 'long-line') are inserted into basilic, cephalic, or brachial veins and enter the superior vena cava or into a large vein. They can be inserted on the ward, but generally inserted in radiology with guided imagery. A chest XRAY is taken to ensure that it is positioned correctly. They are used to deliver medications, fluids, intravenous nutrition, and/or blood products.

Central Venous Access Devices (CVAD) are catheters that provide vascular access terminating in one of the great vessels of the thorax or abdomen. They are used to deliver medications, fluids, intravenous nutrition, and/or blood products. In addition, they may be used for some diagnostic purposes (eg: blood sampling, central venous pressures). Seen in patients requiring IV access for extended periods of time e.g. chemotherapy and cystic fibrosis.

Phlebitis - swelling, redness, heat, and pain related to local inflammation of the vein at or near the cannula site

Selection of IV access type:

To determine the type of IV access that is most appropriate, consider the following:

Number of days IV access is required	Selection of catheter
<7 days	Peripheral IV access
Up to14 days where continued venous access is considered necessary	Peripherally inserted long line/PICC or peripherally inserted central catheter
> 14 days	Peripherally inserted long line/PICC, peripherally inserted central catheter or consider Surgical Line
Long term (> 30 days)	Surgical Line (HICKMAN®/BROVIAC® or Port/Port-A-Cath)

Pain Management

Prior to cannulation apply local anaesthetic cream (AnGel or Emla) to several possible IV sites (e.g. back of hand, cubital fossa) and cover with transparent occlusive dressing i.e. Tegaderm.

Emla Cream: leave for at least 1 hr, but can leave on for several hours without loss of effect. Do not remove until just prior to procedure.

AnGel Cream: leave for 40-60 min prior to procedure. Remove after 60min. Cream will remain effective up to 3 hrs post removal.

Use distraction techniques prior to and during the procedure.

Dressings

The method of dressing the IV ensures security and depends upon the child's age, condition of the skin, site of the IV, child's activity and/or or mobility. Either traditional (tapes and bandage) or the tegaderm/mefix dressing is acceptable.

When dressing a peripheral IV ensure:

- It is secure
- The site is visible so that it can be monitored for phlebitis and infiltration,
- The child can't injure themselves on the connections,
- The child can't remove or dislodge the IV and
- That tapes are not too tight, to prevent tourniquet effect
- All lines have in-line filters on them
- Lines & connections are padded to prevent potential pressure areas by being bound directly to skin areas.

Change the dressing if it becomes insecure or if there is blood or fluid leakage.

Splints

- Part of the dressing for peripheral IVs and to ensure the cannula is not dislodged by the infant/child's movement
- Positioned and strapped with the limb in a natural position to prevent restricting blood or nerve supply
- Should be inspected at least once every shift and changed if soiled by blood or fluid leakage
- Tubifast, not crepe is recommended to keep splint secure

Intermittent infusions

IV lines can be disconnected between doses of medication if fluids are not being given and should be flushed 6 hourly.

IV Labelling

When putting additive to IV Fluid bags or into burettes you must label them with:

- Date
- Time
- Patients name
- Additive name and dose
- Signature of RN's x2 checking the additive.

To indicate when flushing an additive/drug through the line, tear label in half. Once the flush is completed remove the additive label.

IV management

A burette must be connected to all IV lines of Paediatric patients <16yrs & should be filled & read hourly. Fluid flasks are double checked to the patient as are changes to flow rates.

Changing IV bags and lines: All IV bag should be changed every 24 hours and IV lines every 72 hours. Please make sure you have enough orders for the next 24 hours if the patient is to remain on IV fluids.

Changing cannulas

There is no evidence to recommend regularly re-siting IV cannulas in children as is the practice in adults. Cannulas only need to be replaced when they are dislodged, show signs of phlebitis or become blocked.

COMPETENCIES

DRUG ADMINISTRATION CHECKING PROCEDURE PROTOCOL

- Double checking is still required of **ALL** medications.

CARDIAC PULMONARY RESUSCITATION

- Accredited testers for 2 South are available, to identify them ask the ANUM
- All staff to obtain yearly competence.
- Please speak to testers to arrange time.
- Assessment criteria are available on the intranet.

RESPIRATORY ASSESSMENT

- Testers for 2 South: CNS & ANUM
- One off accreditation
- It is ideal to have this competency if you are to care for a respiratory patient
- Assessment criteria is available on the computer

INFORMATION RELATING TO PARENTS

Car Parking

Car Park Closure

- It is anticipated that works will begin on the new Multi Storey Car Park/Helipad on Monday 13th January, 2014 resulting in closure of the current car park for a 12 month period
- Limited short term parking will be available on site during construction for patients/parents
- Due to very limited parking around the hospital site, parents and visitors are asked to allow extra time to locate a parking space, or make alternative arrangements such as public transport

Visiting Hours

- Parents do not have restrictions to normal visiting hours, however only **ONE** parent is allowed to stay overnight. (Exemptions may occur depending on circumstances but must be approved by the nurse in charge). Either a stretcher bed or recliner will be provided with linen for the parent to sleep beside their child's bed. There is one parent flat, but it is used at the discretion of the Nurse in charge & is preferential to breast feeding mothers. We also now have a Family Room where we can accommodate for two parents to stay but this too is used at the discretion of the Nurse in charge.
- After hours parents can re-enter the children's ward by coming in via the emergency reception.

Parent's Pantry

Located off the Atrium just outside of the ward, is the parent's pantry which is for use by all parents of hospitalized children. The key is held at the nurse station and provided to parents upon request. It is asked of all parents and visitors that they ensure that hot drinks brought onto the ward are covered with a lid in order to minimize the risk of scalds and burns which may result from accidental spills. It is encouraged that hot drinks be consumed in the atrium. Bread is also available for toasting to those parents who stay overnight.

Breastfeeding Education and Support Services – Information for Staff

Breastfeeding is supported and encouraged in the unit. Ballarat Health Service is accredited as a Baby Friendly Health Initiative (BFHI) health service. BFHI accreditation aims to provide health care environments where breastfeeding is the norm & where health care practices support, protect and promote breastfeeding.

Staff Breastfeeding Education

Paediatric unit nursing staff are classified as 'Group 2 staff' under BFHI criteria. You are expected to complete at least 2 hours of education related to breastfeeding within 6 months of commencing in your position, and then another 2 hours every 3 years. Regular breastfeeding in-service sessions, twilight seminars and study days are held in conjunction with the Special Care Nursery and Maternity department, and 2 south staff are encouraged to attend these.

All staff should complete a free online program which will take around half an hour. Go to http://babyfriendly2.com.au/moodle/ or search for the South Australian Baby Friendly Online Education Program for Group 2 and 3 staff. Follow the online instructions and complete the ***Group 2*** staff program. Once completed, please forward a copy of your certificate of completion to the Nurse Unit Manager to add to your professional development register. Keep a copy for you own records.

Breastfeeding Service

The BHS Breastfeeding Service provides infant feeding support, advice and education for mothers, babies and their families. The service is staffed by Lactation Consultants (LC's) who are specialists in infant feeding and lactation management. LC's also provide infant feeding and lactation education and support for staff caring for mothers and babies.

The service operates

- Monday – Friday 0800-1630 for inpatients.
  For inpatient consults, please contact the Clinical Midwife Consultant for Lactation hone extension: **96871** or mobile: **0439981937.**
- Monday, Tuesday and Friday from 0900-1530 for outpatient clinic (BF clinic).
  For outpatient clinic bookings, phone extension: **94977**

Breastfeeding Clinical Guidelines

A breastfeeding policy and a range of clinical guidelines are available on the intranet. Go to the Governance Documentation page and search under the Breastfeeding category.
A breastpump is available on the unit for use when required.

HANDY HINTS

Where Am I?
Unlike other wards in the Henry Bolte Wing, rooms within the Paediatric unit are identified by themes and names rather than numbers e.g.: "The Outback" "Disneyland" "Wombat Creek" etc. A signpost in the corridor opposite the nurse station offers directions.

Nappies:
Disposable nappies are provided for infants and can be found in the change room located outside "Peter Rabbit" Additional nappies are stored in the hallway cupboard east of the nurse station. All nappies are disposed on in the green "wheelie bin" in the hallway outside the pan room. Soiled nappies need to be placed in the scented nappy sacks provided prior to disposal.

Infant Bathing:
Portable baby baths are stored in the bathroom and may be prepared here before wheeling to the patient's bed or cot side. Always ensure safe water temperature of just above skin temp (38 - 40ºC) before delivering bath to baby and parent. **Never leave an infant or child unattended in a bath!**

Clothing:
A limited amount of clothing is available for infants and children without an adequate supply of their own. Jumpsuits, pants, singlets and T-shirts can be found in the cupboard in the bathroom & infant change area.

Infant Formula:
All infant formula is stored and prepared in the "milk room" and warmed in hot water filled "warming jugs" before being delivered to parent/infant. OH&S dictates that formula shall not be warmed via microwave oven and that warming jugs shall not be used outside of the milk room. Plastic infant bottles and teats are single use only and are rinsed and disposed for recycling following use. Bottles and teats used by "infectious patients" must not be recycled. Always seek advice of nursing staff if unsure regarding correct.

EBM (Expressed Breast Milk)
EBM is stored in yellow lidded containers placed in the fridge in the milk room. EBM containers must have the patient's bradma label affixed and record the date and time that the milk was expressed. EBM must be checked to the patient by two nurses in the same way that IV drugs are checked to a patient.

Patient Weight:
As paediatric drug doses are calculated on patient weight, not age, all paediatric patients (diagnosis allowing) must be weighed upon admission and this weight recorded on the patient's drug chart and nursing admission documentation. Infants should be weighed naked while older children should be weighed in underwear or light clothing only. Infant scales and weight chair are stored in the bathroom. Variation in patient weight can be critical in determining the condition of the infant/child suffering hydration issues such as "gastroenteritis" and "failure to thrive" and so accurate recording of weight is essential.

Medication Resources:
As paediatric medications are based upon patient's weight, nursing staff routinely check medication orders for accuracy/appropriateness (errors in medical orders are not unheard of!). The "**Paediatric Pharmacopeia**" provides mg per kg dosages for all common paediatric medications while the **"Injectable drug guidelines"** provide dilution requirements, fluid compatibilities and administration rates for IV medications. Both these

resources are kept in the drug room and it is expected that all nursing staff become familiar with their use and application.

Clustering of Nursing Activities:

In caring for the medically "stable" infant or child, nursing interventions and handling activities are often minimized by clustering or grouping these activities together during the child's wakeful periods. For example, an infants feed, bath, medications, nappy change and observations may all be attended together at a time convenient for the child rather than that of the nurse. This minimizes interruption to the child's routine and is often less stress full for both the child and parents alike. It is not always necessary to wake a child prior to delivery of nursing care, many observations (respiratory rate, heart rate, temp, SaO2, respiratory effort etc) can be successfully assessed with a sleeping child.

Be aware however that the child's condition will determine when this approach is appropriate and when it is not.

Consult with senior staff whenever unsure.

Pathology Blood Collection:

Unless urgent, blood collection from paediatric patients is performed by pathology collection staff who visit the ward each weekday, late morning and early afternoon. Weekend and after hours blood collection is performed by senior nursing staff or paediatric medical staff.

Nursing Routine & Responsibilities:

Unlike adult units, the Paediatric and Adolescent Unit do not work to a strict timetable of planned events and tasks. Nursing interventions are timed and delivered to best meet the needs of the individual child and their family. Because of this, time management can sometimes present a challenge for new staff who may be more accustomed to the relatively predictable routine of the adult ward environment. This is not to say that paediatric nursing care cannot be planed or anticipated but rather that its delivery is more flexible and individualized. Time management work sheets are available in the handover room to help with this and paediatric nursing staff will be happy to assist with planning of your patient load.

Apnoea Monitoring:

Apnoea (brief cessation of breathing lasting < 10-20 seconds) in infants is not uncommon (particularly in the premature infant or respiratory compromised infant) so in order to monitor children at risk of apnoea, a sensor is often placed on the child's tummy which monitors respiratory movement of the abdomen. In the absence of movement (apnoea) an alarm sounds alerting staff to a child in respiratory distress. All staff should be familiar with the sound of an alarming apnoea monitor and should respond to such an alarm immediately.

Questions:

"*There is no such thing as a dumb question, only dumb actions*" (anonymous).

There is much to learn in the paediatric environment and often the best way to learn is simply to ask. Our paediatric nursing staff is happy to guide and inform your practice and the ward has many resources available to help you settle into this new nursing environment. If unsure, do not assume, ask.

ORIENTATION PACKAGE ASSESSMENT

1. ***Do you feel the Orientation Package assisted you to settle into the Paediatric and Adolescent Unit?***

2. ***In which ways did you find it beneficial?***

3. ***Can you suggest ways in which the programme can be improved?***

TO BE RETURNED BY ..... / ..... / .....

WHICH IS ONE (1) MONTH AFTER COMMENCING ON WARD.