

Nursing Intervention Basics

With every patient:

- Ensure bedside safety checks complete. Ensure the bedside is a safe space.
- Patient and caregiver/s oriented to space (eg. call bell within reach)
- Patient ID and allergies, ID band on patient.
- Patient weight recorded for this ED visit
- Primary and secondary surveys completed and documented
- Hourly vital signs, increased as indicated by CEWT
- Baseline vital signs (including blood pressure), pain assessment and neurological observations (Glasgow Coma Scale (GCS), pupil assessment and limb strengths)



ALERT

The nursing scope of practice will vary between settings. Always ensure you are working within the scope of the workplace that you are in. Standing orders, work instructions, procedures or similar will dictate your scope. Please confirm with your nurse managers and educators what applies in your workplace.

STRIDOR

- Keep patient calm
- Cluster cares to minimise distress
- Hourly respiratory assessment (minimum frequency)
- When prescribed nebulised adrenaline: 1:1 nursing care with continuous oxygen saturation and cardiac monitoring
- Could this be a foreign body?



INCREASED WORK OF BREATHING / WHEEZE

- Hourly respiratory assessment (minimum frequency)
- Look / Listen / Feel
- Continuous SpO₂ monitoring
- Refer to Pre-School Wheeze / Asthma Flowchart as appropriate
- Give prescribed inhalers on time
- Could this be a foreign body?

ABDOMINAL PAIN / VOMITING / DIARRHOEA / ↓ INPUT & OUTPUT

- Point of Care (POC) Blood Glucose Level (BGL) +/- Ketones
- Consider clean catch urine
- Consider topical anaesthetic if bloods or peripheral cannula placement is anticipated
- Strict fluid balance
- Consider Oral Trial of Fluids

CHEST PAIN

- 12-lead ECG
- Continuous cardiac monitoring
- Consider topical anaesthetic if bloods or peripheral cannula placement is anticipated
- Baseline respiratory assessment (continue minimum hourly if abnormal)
- Ensure access to Paediatric ECG Checklist (QH only)

FEVER

- Could it be SEPSIS?
Commence Sepsis Pathway
- Conduct skin check (eg. rashes)
- Consider topical anaesthetic if bloods or peripheral cannula placement is anticipated
- Strict Fluid Balance
- Consider likely other diagnostics required - eg. clean catch urine
- Consider antipyretics/analgesics where there is pain/distress

NEONATES

- Bare weight
- Strict fluid balance
- Record time breastfeeding in minutes
- Where available, conduct transcutaneous bilirubin test where neonate meets testing criteria
- Where indicated: capillary blood gas for bilirubin levels
- BGL & ketones if concerns of feeding
- Consider pre and post ductal SpO₂
- Consider 4 limb blood pressures
- Consider ECG

TOXIC EXPOSURE / OVERDOSE

- 12-lead ECG
- Continuous cardiac monitoring
- Neurological observations (GCS, pupils & limb strengths)
- Consider applying topical anaesthetic if bloods non-immediate
- POC BGL

MENTAL HEALTH

- Complete mental health screening
- Complete SAT score
- Conduct regular visual observations as per local policy
- Check for patient management plan
- Address medical aspects of presentation concurrently

ACUTE LOSS OF CONCIIOUSNESS

- 12-lead ECG
- Continuous cardiac monitoring
- Postural blood pressure & pulse
- Neurological observations (GCS, pupils & limb strengths)
- POC BGL


SEIZURE

- 12-lead ECG
- Neurological observations (GCS, pupils & limb strengths)
- POC BGL
- Consider topical anaesthetic if bloods or peripheral cannula placement is anticipated

HEAD INJURY

- Consider C-Spine precautions
- Minimum hourly neurological observations (GCS, pupils & limb strengths)

UNEXPLAINED HYPOGLYCEMIA

- POC BGL & ketones
- If BGL <3.0mmol immediately alert
-  SMO follow Unexplained Hypoglycemia Guideline
- If BGL <2.6mmol confirmed on VBG, prepare 2mL/kg dose of Glucose 10%, followed by maintenance fluids of 10% Glucose in 0.9% Sodium Chloride (follow CREDD recipe to prepare)

MUSCULOSKELETAL INJURY

- Consider C-Spine precautions
- Conduct pain assessment and offer timely analgesia
- Hourly neurovascular observations
- Apply RICE principles
- Consider NBM if sedation or operating theatre likely



Other skill sheets for further information:

- [Nursing Orientation to Paediatric Emergency](#)
- [Rapid Assessment](#)
- [Primary Survey](#)
- [Obtaining Vital Signs in Infants and Children](#)
- [Acute Pain Assessment](#)
- [Physiological and Anatomical Differences in Children](#)
- [Respiratory Assessment](#)
- [Cardiovascular Assessment](#)
- [ECG in children](#)
- [ECG in neonates](#)
- [Neurological Assessment](#)
- [Clean Catch Urine](#)
- [Hydration Assessment](#)
- [Oral Trial of Fluids](#)

This list is not exhaustive. Please refer to the [QPEC Skill Sheets and Videos](#) page for more skill sheets.

Clinical guidelines for further information:

- [Asthma](#)
- [Bronchiolitis](#)
- [Cervical Spine Injury](#)
- [Croup](#)
- [Gastroenteritis](#)
- [Neonatal Guidelines \(Queensland Clinical Guidelines\)](#)
- [Pre-School Wheeze](#)
- [Sepsis](#)
- [Status Epilepticus](#)
- [Unexplained hypoglycaemia](#)
- [Urinary Tract Infection](#)

This list is not exhaustive. Please visit the [QPEC Clinical Guidelines](#) page for more guidelines.

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- Providing care within the context of locally available resources, expertise, and scope of practice.
- Supporting consumer rights and informed decision making in partnership with healthcare practitioners including the right to decline intervention or ongoing management.

- Advising consumers of their choices in an environment that is culturally appropriate and which enables comfortable and confidential discussion. This includes the use of interpreter services where necessary.
- Ensuring informed consent is obtained prior to delivering care.
- Meeting all legislative requirements and professional standards.
- Applying standard precautions, and additional precautions as necessary, when delivering care.
- Documenting all care in accordance with mandatory and local requirements.

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