Zuckerberg San Francisco General Hospital and Trauma Center

Children's Health Center

STANDARDIZED PROCEDURE

REGISTERED NURSE

Zuckerberg San Francisco General Hospital
Children's Health Center

Standardized Procedures:

Introduction

The following protocols are the policies and guidelines for the care provided to pediatric patients at the Zuckerberg San Francisco General Hospital and Trauma Center (SFGH) Children's Health Center Urgent Care Clinic. Since it is impossible to anticipate every clinical situation or presenting chief complaint that may arise, it is expected that an Attending Physician consultation and evaluation will be warranted. The RN will refer any patient for an evaluation by an attending physician in the Children's Health Center. The RN shall function within the scope of practice as specified in the State of California Nurse Practice Act.

The Standardized Procedures were developed with assistance from the following:

1. Implementation of Standardized Procedures. Position Statement of the California Nurse Association
2. Standardized Procedure Work Sheet, State of California Board of Registered Nursing, Department of Consumer Affairs.

San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE ~ REGISTERED NURSE

Title: Registered Nurse in the Children's Health Center

I. Policy Statement

A. It is the policy of Zuckerberg San Francisco General Hospital Medical Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Registered Nurses, Physicians, Administrators and other Affiliated Staff and conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. A copy of the signed procedures will be kept in an operational manual in the Children's Health Center and on file in the credentialing liaison Medical Staff Office.

Protocol #1: Shortness of Breath with Wheezes (Asthma)

A. Definition
This protocol covers the initial assessment and management of children with shortness of breath with wheeze seen by Registered Nurses (RN) in the Children's Health Center.
Indications: Shortness of breath with confirmed wheezing and history of asthma

B. Data Base
1. Subjective Data
   a) Review history and signs and symptoms of asthma/COPD
   b) Obtain pertinent past medical history, current medications and allergies
   c) Note characteristics of shortness of breath and associated symptoms (cough, fever, chills)
   d) Describe any treatments used prior to arrival

2. Objective Data
   a) Perform focused physical exam relevant to respiratory disease
   Obtain the following respiratory vitals and repeat every 1 hour throughout clinic stay
   b) Respiratory rate (count for minimum of 60 seconds) ○ Auscultate lung sounds bilaterally
      i. Note depth and work of breathing
      ii. Note stridor or audible wheezing, nasal flaring, grunting, retractions
   c) Place on pulse oximetry and measure SpO2
   Obtain the following additional vitals and repeat every 2 hours throughout clinic stay

      i. Pulse
      ii. Core temperature
      < 6 months of age: rectal temp
      6-12 months: Tympanic. If >38.5°C, follow up with rectal
      12 months: tympanic or oral depending on patient .cooperation
      Rectal Temp at provider request
      iii. Blood pressure (child with temp> 38°C)
      iv. Note skin signs: color, temperature, moisture, and capillary refill

C. Assessment
Consistent with subjective and objective findings and disease status

D. Plan
1. Treatment
   a) Notify Physicianimmediately for any child requiring O2 mask or with moderate-severe respiratory distress
   b) Initiate oxygen via face mask at 10 liters/minute for any child with saturation <94%. Titrate to maintain SpO_2 >94%
   c) Obtain order from Physician for nebulized albuterol sulfate 2.5mg and ipratropium bromide (atrovent) 0.5mg for children who are assessed as having significant wheezing or saturation <94% with associated wheezing. (Physician may modify as necessary).

2. Prompt consultation with Physician for altered vital signs:

Child < 3 months
- HR > 180
  < 100
- RR > 60
  < 30
-SpO2 < 94%
-Temp > 38°C

Child 3-6 months
- HR >170
  < 90
- RR > 40
  < 25
- SpO_2 < 94%
- Temp> 38°C

Child 6months – 12 months
- HR > 150
  < 90
- RR > 35
  < 20
- SpO_2 < 94%
- Temp> 38.5°C

Child 1 year – 6 years
- HR > 130
  < 80
- RR > 30

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< 20
- SpO2 < 94%
- Temp> 38.5°C

Child 6 years – 12 years

- HR > 120
  < 65
- RR > 30
  < 18
- SpO2 < 94%
- Temp> 38.5°C

Child > 12 years

- HR > 110
  < 60
- RR > 25
  < 15
- SpO2 < 94%
- Temp > 39°C

3. Transport to patient care area for evaluation by Physician.

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4. Education
   a) Patient/parent education and counseling appropriate to disease process
   b) Asthma education to be done by Health Workers from asthma clinic

5. Follow-Up
   Primary care provider as appropriate to monitor treatment, medication, and activities

E. Record Keeping

All information relevant to patient care will be recorded in the medical record and LCR as appropriate.

Protocol # 2: Nausea, Vomiting and Diarrhea

A. Definition

This protocol covers the initial assessment and management of patients with nausea, vomiting and diarrhea related symptoms seen by Registered Nurses (RN) in the Children's Health Center

Indications:

1. Diarrhea >24 hours
2. No urination >24hours
3. Abdominal pain >4 hours
4. Headaches
5. Dysuria
6. Fevers
7. Vomiting > 12 hours (<6 months)
   > 24 hours (6 months – 2 years)
   > 48 hours (> 2 years old)

B. Data Base

1. Subjective Data
   a) Review history and signs and symptoms related to dehydration
      i. Last oral intake
      ii. Tearing (note with or without crying)
   b) Fever, chills
   c) Frequency, amount, and color of stool and urine
   d) Frequency, amount and color of emesis
   e) Note pertinent past medical history, current medications and allergies
   f) Document characteristics of any pain location, quality, and intensity (0-10)
   g) Describe abdominal cramping
   h) List any treatments used prior to arrival
   i) Travel History

2 Objective Data
   a) Perform focused physical exam relevant to dehydration:
   b) ***Obtain complete set of vitals every hour X 2 and then every 2 hrs.***
      i. Respiratory Rate (count for a minimum of 60 seconds)
      ii. Pulse
      iii. Core Temperature:
      < 6 months: rectal temp
      6months- 12 months: tympanic. If > 38.5°C, follow up with rectal.

12 months: tympanic or oral depending on pt. cooperation Rectal temp at provider request

i. Blood Pressure (child with temp> 38°C)
ii. Place on pulse oximetry and measure SpO2
iii. Note skin signs: color, temperature, moisture, and capillary refill
iv. Describe level of activity: active, lethargic
v. Check anterior fontanel in children < 12 months
vi. Document fussiness/irritability

C. Assessment
Consistent with subjective and objective findings and status of disease process

D. Plan
1. Treatment
a) Save any stool samples
b) Prompt consultation with Physician if vital signs are out of age-specific norms

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Child < 3 months
- HR > 180
< 100
- RR > 60
< 30
- SpO_2 < 94%
- Temp> 38C

Child 3-6 months
- HR >170
< 90
- RR > 40
< 25
- SpO_2 < 94%
- Temp> 38.5C

Child 6 months – 12 months
- HR > 150
< 90
- RR > 35
< 20
- SpO_2 < 94%
- Temp> 38.5°C

Child 12 months - 6 years
- HR > 130
  < 80
- RR > 30
  < 20
- SpO2 < 94%
- Temp > 38.5°C

Child 6 years – 12 years
- HR > 120
  < 65
- RR > 30
  < 18
-SpO2 < 94%
-Temp> 38.5°C

Child > 12 years
-HR > 110
  < 60
-RR > 25
  < 15
-SpO2 < 94%
-Temp> 39°C

No urination for> 24 hours
Altered mental status with Glascow Scale < 13

c) Request order from physician for anti-emetic or anti-pyretic medication if indicated.
d) Transfer to patient care area for evaluation by Physician
e) Education
   i. Patient or family education and counseling appropriate to disease process.

2. Follow Up
   Primary Care Provider as appropriate to monitor treatment, medication, and activities

E. Record Keeping
All information relevant to patient care will be recorded in the medical record and LCR as appropriate.

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Protocol #3: Abdominal Pain

A. Definition

This protocol covers the initial assessment and management of children with abdominal pain which may include but not limited to vomiting and diarrhea seen by the Registered Nurse (RN) in the Children's Health Center.

1. Indications:
   b) Vomiting more than two times a day
   c) Diarrhea/loose watery stool, mucousy >24 hours
   d) Vital signs suggesting hemodynamic instability (HR or BP outside the normal range)
   e) Dizzy or unstable when standing
   f) Severe abdominal pain >24 hours

B, Data Base

1. Subjective Data
   a) Review history and signs and symptoms suggestive of volume loss
   b) Frequency, amount, and color of emesis
   c) Frequency, amount, and color of stool and urine
   d) Note pertinent past medical history, current medications and allergies
   e) List characteristics of any pain location, quality, and intensity (0-10) and associated symptoms (abdominal pain, fever, chills)
   f) Describe any treatments used prior to arrival

2. Objective Data
   a) Perform focused physical exam relevant to gastrointestinal disorders. Auscultate bowel sounds and note abdominal distension

   b) Measure vital signs every hour x 2, then every 2 hours
      i. Respiratory Rate (count for minimum of 60 seconds)
      ii. Pulse
      iii. Core Temperature:
         < 6 month: rectal temperature
         6 months - 12 months: tympanic. If > 38.5°C, follow up with a rectal temp
         1 year: tympanic or oral depending on pt. cooperation
      iv. Rectal temp at provider request
      v. Blood pressure (child with temp> 38°C)
   c) Place on pulse oximetry and measure SpO_2.
   d) Note skin signs: color, temperature, moisture, and capillary refill
   e) Collect urine sample after consultation with Physician.

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C. Assessment

Consistent with subjective and objective findings and status of disease process.

D. Plan

1. Treatment
   a) Request order from physician for anti-emetic or anti-pyretic medication if indicated
   b) Save stool sample if diarrhea
   c) Keep NPO until seen by provider
2. Patient education and counseling appropriate to disease process

g) 3. Prompt consultation with physician if vital signs are out of age-specific norms

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Child < 3 months
- HR > 180
  < 100
- RR > 60
  < 30
- SpO_2 < 94%
- Temp> 38°C

Child 3 months – 6 months
- HR >170
  < 90
- RR > 40
  < 25
- SpO_2 < 94%
- Temp> 38°C

Child 6 months – 12 months
- HR > 150
  < 90
- RR > 35
  < 20
- SpO_2 < 94%
- Temp> 38.5°C

Child 1 year – 6 years
- HR > 130
  < 80
- RR > 30
  < 20
- SpO2 < 94%

- Temp> 38.5°C

Child 6 years – 12 years
-HR > 120
< 65
-RR > 30
< 15
-SpO2 < 94%
-Temp> 38.5°C

Child > 12 years
-HR > 110
< 60
-RR > 25
< 15
-SpO2 < 94%
-Temp> 39°C

a) Altered mental status with GCS <13 (Keep Glascow scale accessible in the binder on the unit.)
b) Vomiting more than two times in Urgent Care Clinic prior to being seen by Physician

4. Transport to patient care area for evaluation by physician
5. Follow-up
Primary Care Provider as appropriate to monitor treatment, medication and activities

E. Record Keeping
All information relevant to patient care will be recorded in the medical record or LCR as appropriate.

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Protocol #4: Febrile Seizure

A. Definition

This protocol covers the initial assessment and management of children who present following a febrile seizure seen by the Registered Nurse in the Children's Health Center

B. Data Base

1. Subjective Data
   a) Review history and signs and symptoms of febrile seizures
   b) Note pertinent past medical history, current medications and allergies
   c) List characteristics of seizure activity, post ictal state
   d) Describe any treatments used prior to arrival

2. Objective Data
   a). Perform focused physical exam relevant to seizure activity
      i. Check of level of responsiveness
      ii. Document if child was seizing upon arrival
   b). ***Measure vital signs every 30 minutes X 2, then every 1 hour***
      i. Respiratory rate (count for minimum of 60 seconds)
      ii. Pulse
      iii. Blood Pressure (child with temp> 38°C)
      iv. Core temperature:
         < 6 months: rectal temp
         6 months – 12 months: tympanic. If > 38.5°C, follow up with rectal temp
         1 year: tympanic or oral depending on pt. cooperation
      v. Rectal temp at provider request
   c). Place on pulse oximetry to measure SpO_2 saturation.

C. Assessment

Consistent with subjective and objective findings and status of disease process

D. Plan

1. Treatment
   a) Initiate oxygen via face mask at 10 liters/minute. Titrate to maintain Sp02 >94%
   b) Administer Acetaminophen or Ibuprofen as prescribed by Physician for fever >39° C

c) c) Prompt consultation with Physician if vital signs are out of age-specific norms

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Child < 3 months
- HR > 180
  < 100
- RR > 60
  < 30
- SpO_2 < 94%
- Temp> 38C

Child 3-6 months
- HR >170
  < 90
- RR > 40
  < 25
- SpO_2 < 94%
- Temp> 38°C

Child 6 months – 12 months
- HR > 150
  < 90
- RR > 35
  < 20
- SpO_2 < 94%
- Temp> 38.5°C

Child 1 year – 6 years
- HR > 130
  < 80
- RR > 30
  < 20
-SpO2 < 94%
-Temp> 38.5°C

Child 6 years – 12 years
-HR > 120
  < 65
-RR > 30
  < 18
-SpO2 < 94%
-Temp > 38.5°C

Child > 12 years

-HR > 110
< 60

-RR > 25
< 15
-SpO2 < 94% -
Temp> 39°C
Altered mental
status

1. Education and counseling appropriate to disease process
2. Transport to patient care area for evaluation by Physician
3. Follow-Up with Primary Care Provider as appropriate to monitor treatment, medication and activities.

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E. Record Keeping

All information relevant to patient care will be recorded in the medical record or LCR as appropriate.

Protocol #5: Urinary Tract Infection

A. Definition

This protocol covers the initial assessment and management of children with urinary tract infection seen by the Registered Nurse in the Children's Health Center.

B. Data Base

1. Subjective Data:
   a) Review history and signs and symptoms of painful urination
   b) Document characteristics of urination problems: frequency/diaper count, pain with urination/flank pain or abdominal pain, smell, color, presence of blood in the urine.
   c) Note pertinent past medical history, hospitalizations, current medications and allergies
   d) List any treatments used prior to arrival
   e) Pain assessment

2. Objective Data
   a) Respiratory Rate (count for a minimum of 60 seconds)
   b) Pulse
   c) Blood Pressure (child with temp> 38°C)
   d) Core temperature:
      < 6 months: rectal temp
      > 6 months – 12 months: tympanic. If > 38.5°C, follow up with rectal
      > 1 year: tympanic or oral depending of pt. cooperation
      Rectal temp at provider request

C. Assessment

a) Assessment consistent with subjective and objective findings and disease process

D. Plan

1. Treatment
   a) Urine collection for urine analysis
   b) If > 14 years of age, obtain 2 urine specimens: Gonorrhea/Chlamydia and a clean catch for urine analysis
   c) Prompt consultation with Physician if vital signs are out of age specific range

Child < 3 months

- HR > 180
< 100
-RR > 60
< 30

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- Temp >38°C

Child 3-6 months
- HR >170
  < 90
- RR > 40
  < 25
- Temp >38°C

Child 6 months – 12 months
- HR > 150
  < 90
- RR > 35
  < 20
- Temp> 38.5°C

Child 1 year – 6 years
-HR > 130
  < 80
-RR > 30
  < 20
-Temp> 38.5°C

Child 6 years – 12 years
-HR > 120
  < 65
-RR > 30
  < 18
-Temp> 38.5°C

Child 12 years
-HR > 110
  < 60
-RR > 25
  < 15
-Temp> 39°C

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Urine dipstick with RBC's >3, Protein-trace, WBC >5

2. Education
   Patient Education and counseling appropriate to disease process

3. Transport to patient care area for evaluation by Physician.

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1. Follow-Up

Primary Care Provider as appropriate to monitor treatment, medication and activities.

2. Record Keeping

All information relevant to patient care will be recorded in the medical record or LCR as appropriate.

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Protocol # 6: Rash and Fever

3. Definition

This protocol covers the initial assessment and management of children with generalized rash and fever seen by the Registered Nurse in the Children's Health Center. To prevent the transmission of chicken pox, measles, meningococcus and other infections in waiting room and other clinical areas.

B. Data Base

1. Subjective Data
   a) Review history and signs and symptoms of fever with or without rash
   b) Note characteristics of rash, redness of skin, generalized/localized, itchy, burning, etc
   c) Document fever, irritability, fussiness
   d) List pertinent past medical history, hospitalizations, current medications and allergies, exposure to someone with same symptoms
   e) Describe any treatments used prior to arrival
   f) Pain Assessment (Scale 0-10)
   g) Travel history

4. Objective Data

   a) Perform focused physical exam relevant to fevers and rash
   b) Identify location of rash, describe appearance (erythematous, shiny, petechiae, purpura, rough, blisters, oozing, etc.) and size.
   c) Measure vital signs every 2 hours
      i. Respiratory Rate (count for a minimum of 60 seconds)
      ii. Pulse
      iii. Blood Pressure (child with > 38°C temp)
      iv. Core temperature
         < 6 months: rectal temp
         6 months- 12 months: tympanic. If > 38.5°C, follow up with rectal tem
         > 1 year: tympanic or oral depending on pt. cooperation
         Rectal temp at provider request
      v. Depending on findings, may need to isolate patient in a room away from other children and families.

5. Assessment

Consistent with subjective and objective findings and status of disease process

D. Plan

1. Treatment
   a) Examine body and describe rash (for generalized redness, purpura or petechiae) • If petechial or non-blanching, notify Physician immediately
   b) Assess child for general conditions (runny nose, high fever, pink eye,

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Cough, loss of appetite, altered mental status)

c) Isolate patient in room away from other patients

d) Transport to patient care area for evaluation by Physician

e) Prompt consultation with physician if vital signs are out of age-specific range;

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Child < 3 months

- HR > 180
  < 100
- RR > 60
  < 30
- Temp >38C

Child 3-6 months

- HR >170
  < 90
- RR > 40
  < 25
-T > 38°C

Child 6 months – 12 months

- HR > 150
  < 90
- RR > 35
  < 20
- Temp> 38.5°C

Child 1year – 6 years

-HR > 130
  < 80
-RR > 30
  < 20
-Temp> 38.5°C

Child 6 years – 12 years

-HR > 120
  < 65
-RR > 30
  < 18
-Temp> 38.5°C

Child > 12 years

-HR > 110

< 60
-RR > 25
< 15

-Temp> 39°C

2. Education
   Patient/family education and counseling appropriate to disease process

3) Follow-Up
   Primary Care Provider as appropriate to monitor treatment, medication and activities.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate.

Protocol #7: Suspected Fractures

A. Definition

This protocol covers the initial assessment and management of children with suspected fractures seen by the Registered Nurse in the Children's Health Center.

B. Data Base

1. Subjective Data
   a) Chief complaint
   b) Patient history, and signs and symptoms (to relevant findings)
   c) Pain assessment (scale 0-10)
   d) Any treatment used prior to arrival, recent Physician visits

2. Objective Data
   a) Perform limited physical exam appropriate to suspected fractures
   b) Note ability to move extremities or ambulate
   c) Describe perfusion of extremity
   d) Measure Vital signs at initial assessment
      i. Respiratory Rate (count for a minimum of 60 seconds)
      ii. Pulse
      iii. Blood Pressure (child with temp> 38°C)
      iv. Core temperature:
         < 6 months: rectal temp
         6 months – 12 months: tympanic. If > 38.5°C, follow up with rectal temp
         1 year: tympanic or oral depending on pt. cooperation
      v. Rectal temp at provider request

C. Assessment

Consistent with subjective and objective findings and status of disease process/injury

D. Plan

1. Treatment
   a) If gross deformity or severe pain/swelling or high suspicion of fracture, notify Physician to determine if x-rays need to be taken before rooming patient
   b) Transport to patient care area for evaluation by Physician.
   c) Initiation of pain control measures in consultation with Physician as indicated.
   d) Apply ice
   e) Treatment will be determined by Physician based on age of patient, severity of fracture, and type of fracture.
   f) Initiation of radiological studies per Medical Screening Exam and consultation with Physician
   a) Prompt consultation with Physician regarding appropriate reporting to Child Protective.

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g) Prompt consultation with physician for vital signs out of age-specific range:

Child < 3 months

-HR > 180
< 100 -RR > 60
< 30
-Temp > 38°C

Child 3-6 months

-HR > 170
< 90

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-RR > 40
< 25
-Temp> 38°C

Child 6 months – 12 months
-HR > 150
< 90
-RR > 35
< 20
-Temp> 38.5°C

Child 1 year–6 years

-HR > 130
< 80
-RR > 30
< 20
-Temp. > 38.5°C

Child 6 years – 12 years
- HR > 120
< 65
-RR > 30
< 18
-Temp> 38.5°C

Child > 12 years

-HR > 110
< 60
-RR > 25
< 15
-Temp> 39°C

2. Education
   Patient and family education appropriate to diagnosis including treatment modalities, medications, and activity
3. Documentation of radiological study ordered
   Follow-Up
   Primary Care Provider as appropriate to monitor treatment, medication and

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activities.

E. Record Keeping

All information relevant to patient care will be recorded in the medical record or LCR as appropriate.

Protocol # 8: Lacerations

A. Definition: This protocol covers the initial assessment and management of children with lacerations seen by the Registered Nurse in the Children's Health Center.

Indications

1. Lacerations <5cm involving extremities, trunk, or face
2. Vital signs suggesting hemodynamic instability (HR>130, or SBP <90, dizzy when standing)

B. Data Base

1. Subjective Data
   a) Review history and signs and symptoms suggestive of volume loss; frequency, amount
   b) Pertinent past medical history
   c) Current medications, allergies
   d) Any treatment or medications prior to arrival
   e) Pain Assessment (Scale 0-10)

2. Objective Data
   a) Perform physical examination of laceration site, depth, width, location, bleeding
   b) Measure vital signs at initial assessment and then every 2 hours
      i. Respiratory Rate (count for a minimum of 60 seconds)
      ii. Pulse
      iii. Blood Pressure (child with temp> 38°C)
      iv. Core Temperature:
         < 6 months: rectal
         6 months – 12 months: tympanic. If > 38.5°C, follow up with rectal temp
         1 year: tympanic or oral depending on pt. cooperation
         Rectal temp at provider request
   c) Note skin signs, color, temperature, moisture, and capillary refill if lacerations on extremities

C. Assessment

Consistent with subjective and objective findings and status of disease process

D. Plan

1. Treatment
   a) For all lacerations, consult with Physician to determine appropriateness of treatment at Children's Health Center. May need to transport to ED for suturing
   b) Initiate pain control measures in consultation with Physician

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c) Update immunization status in consultation with Physician

d) Prompt consultation with physician for vital signs out of age-specific range:

Child < 3 months

-HR > 180
< 100
-RR > 60
< 30
- Temp > 38°C

Child 3 - 6 months

-HR > 170
< 90
-RR > 40
< 25
-Temp> 38°C

Child 6 months – 12 months

-HR > 150
< 90
-RR > 35
< 20
-Temp >38.5°C

Child 1 year – 6 years

-HR > 130
< 80
-RR > 30
< 20
-Temp> 38.5°C

Child 6 years – 12 years

-HR > 110
< 60
-RR > 25
< 15
-Temp> 39°C

Child > 12 years

-HR > 110
< 60
-RR > 25
< 15

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-Temp> 39°C

2. Education
   Patient/family education and counseling appropriate to the diagnosis including treatment, medication, and activities

3. Follow-Up
   Primary Care Provider as appropriate to monitor treatment, medication and activities.

E. Record Keeping
   All information relevant to patient care will be recorded in the medical record or LCR as appropriate.

Protocol #9: Child Protection Center (CPC) Clearance Exams

A. Definition: This protocol covers the initial assessment and management of children seen for CPC clearance by the Registered Nurse in the Children's Health Center.

B. Data Base

1. Subjective Data
   a) Review pertinent past medical history (if possible)
   b) Review current signs and symptoms
   c) Pain assessment (Scale 0-10)

2. Objective Data

   Limited physical exam appropriate for any complaint, which may include but are not limited to:

   a) Vital Signs: Full vital signs re-assessed every 2 hours as long as patient remains in Urgent Care Clinic
      i. Respiratory Rate (count for minimum of 60 seconds)
      ii. Pulse
      iii. Blood Pressure (any child with fever >38°C)
      iv. Core temperature:
      v. <6 months: Rectal temperature
      vi. 6 months – 12 months: Tympanic. If > 38.5°C, follow up with a rectal
      vii. temp
      viii. >12 months: Tympanic or oral depending on patient cooperation

      Rectal temp at provider request
   b) Oxygen saturation for anyone presenting with respiratory symptoms or decreased level of consciousness
   c) Assessment if symptoms of pregnancy or possible labor, as appropriate
   d) Emotional state
   e) Skin signs (i.e. color, temperature, moisture, capillary refill)
   f) Physical appearance, size and locations of injuries, assessment of distal circulation, movement and sensation, as appropriate
   g) Ability to ambulate and assessment of gait, as appropriate.

C. Assessment

Consistent with subjective and objective findings and disease status

D. Plan

1. Treatment
   a) Prompt consultation with physician for vital signs out of age-specific range:

Child < 3 months

- HR > 180
  <100
- RR > 60

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<30

- SpO2 < 94%
- Temp >38°C

Child 3-6 months
- HR > 170
  <90
- RR >40
  <25
- SpO2 < 94%
- Temp> 38°C

Child >6months – 12 months
- HR > 150
  <90
- RR >35
  <20
- SpO2 < 94%
- Temp >38.5°C

Child 1 year–6 years
- HR >130
  <80
- RR >30
  <20
- SpO2 <94%
- Temp> 38.5°C

Child 6 years – 12 years
- HR > 120
  <65
- RR > 30
  <18
- SpO2 < 94%
- Temp> 38.5°C

Child > 12 years
- HR > 110
  <60
- RR > 25
  <15
- SpO2 < 94%
- Temp> 39°C

b) Transport patient to patient care area for evaluation by Physician. CPC patients should be roomed before all patients who are> 6 months with normal VS, and no acute pain or respiratory distress, even if they arrived later

c) Give patients> 14 years old a urine collection cup for first void urine to assess for Gonorrhea/Chlamydia.

d) Notify Physician that CPC patient has been roomed and is a ready for evaluation

e) Age appropriate screening and/or diagnostic tests for purposes of disease identification.

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E. Record Keeping

All information relevant to patient care will be recorded in the medical record and

LCR as appropriate.