

**Allergies and Adverse Reactions** (ADR)  $\Box$  Yes (see patient medication chart) 🗆 Nil known 🛛 Unknown

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE  $\wedge$ 

First prescriber to print patient name and check label is correct:

Intraveno	us Fluid Orders All fluids I If administ	must be re ering blood	eviewed a	nd rewritten 24 hourly, refer to local hospital o	<b>y.</b> documentation.			
	Medical officer p	rescriptio	n			Nurse	administratio	n
Date/time ordered	Fluid type and additives	Total volume	Rate mL/hr	Prescriber name/sign/pager	Date/time commenced		Nurse 1 Nurse 2	Date/tim infusion ceased
/ /					/ / :	1 2		/ /
/ /					/ /	1 2		. / /
/ /					/ /	1		/ /
/ /					/ /	1		. / /
/ / :					/ /	1		
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Enteral O	r <b>ders</b> Refer to local procedure for wh	no orders e	nteral fee	ds.	† Nurse ad	ministr	ation checks in	iside pages.
Date/time ordered	Type and additives	Route	Rate / Administra e.g. 300mL every 4 ho e.g. 10mL/hr continuo	s ours	Clinician / Dietitian Name / Sign / Number			
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Victorian Children's Tool for **Observation and Response** 24 Hour Fluid Management Chart Midday to Midday

**Paediatrics** 

UR NUMBER SURNAME GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE  $\wedge$ 

/ to	/ /										
n weight kg	Current weight Date/Time:	kg kg weig	Review of change in weight is the gold standard in paediatric fluid management. Refer to hospital weight chart to review weight trends.								
This patient has complex fluid requirements. The below calculations may not apply. Please refer to the patient plan / notes for specific fluid needs.         Tick if relevant       Signed: Designation:											
<b>CALCULATING FLUID REQUIREMENTS</b> Medical staff to complete when required. See inside page for who needs a TFI calculated.											
ous Resuscitati	on only if required		Not to be included in								
g bolus of Sodium	Chloride 0.9% then reas	sess									
ance Hydration Id Enteral Routes)		Note: this does not	t represent daily nutritional requirements for gr								
$4mL / kg / hr for the first 10kg = $ $2mL / kg / hr for 11 - 20kg = $ $mL / hr full maintenance$ $mL / hr adjusted rate *$ $* Generally 2/3 maintenance rate should initially be used in unwell children unless they are dehydrated. See back page for guide.$ $\boxed{\Theta - mL / hr x 24 hours}$											
C. Replacement See Statewide CPGs ' <i>Dehydration</i> ' for deficit calculation, and ' <i>Gastroenteriti</i> s' for total rates											
Pre-Existing Deficit (mL): weight (kg) x deficit % x10. Replace over 24–48 hrs Ongoing losses: replace as medically directed											
TOTAL FLUID INTAKE PLAN (TFI) PLAN											
aintenance	<b>O</b>	eplacement	⊖ mL/24 hours*								
	/       to         In weight       kg         In weight       kg         This patient has or plan / notes for special staff to plan / notes fo	/       to       /       /         In weight       Current weight         kg       Date/Time:         Date/Time:	/       to       /       /         In weight       Current weight       Revision								

Paediatric Intravence	ous Fluid Types
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Refer to Statewide Clinical Practice Guideline 'Intravenous Fluids' for fluid type calculation and monitoring (available on the The Royal Children's Hospital website www.rch.org.au). Be sure to consider maintenance, deficits, ongoing losses and electrolyte abnormalities.

Fluid Type	Uses
Sodium Chloride 0.9%	For initial boluses
Sodium Chloride 0.9% and Glucose 5% +/- 20mmol/L Potassium Chloride <i>OR</i> Plasma-Lyte 148 and Glucose 5% (contains 5mmol/L of Potassium Chloride)	For maintenance hydration (for neonates, discuss with Senior Consultant/Paediatrician)

The above fluids are suitable for replacement of deficit and/or replacement of losses.

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## Paediatric Maintenance IV Rates

This guideline should be used as a starting point and will need to be adjusted in ALL unwell children.

Generally 2/3 of maintenance rate should be used in unwell children unless they are dehydrated. This is because they are likely to be secreting anti-diuretic hormone (ADH), so will need less fluid.

Children with meningitis or other acute CNS conditions will likely require additional fluid restriction – seek senior advice.

For dehydration in children, refer to Statewide Clinical Practice Guideline 'Dehydration' for further details.

Weight (kg)	Full maintenance (mL / hr)	2/3 maintenance (mL/hr)
3	12	8
4	16	11
5	20	13
6	24	16
7	28	18
8	32	21
9	36	24
10	40	27
12	44	29
14	48	32
16	52	35
18	56	37
20	60	40
25	65	43
30	70	47
35	75	50
40	80	53
45	85	57
50	90	60
55	95	63
60	100	67
65	105	70
70	110	73
75	115	77
80	120	80
≥ 85	125	83

VICTOR 24

Hour Fluid Management Chart

Paediatrics

(VPFM001)

## Victorian Children's Tool for Observation and Response 24 Hour Fluid Management Chart Midday to Midday – Paediatrics

Date: / / to / /

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NG/NJ tube position: $\Box$ L $\Box$ R	Tube size:				
Taped at: cm	Tube change due:				
IV cannula inserted: 1	2				
Line change due: 1	2				

Additional instructions:	Previous days balance:	UR NUMBER
		SURNAME
	mL	GIVEN NAME
		DATE OF BIR
		AFFIX PATIE

											Inp	out* (r	nL)											(
	IVC	; site					Infusion	S							Oral/Ente	eral						Urir	ne	
	che	ecks	Site:			Site:			Site:			Prog.					Route	I	Prog.					
			Fluid typ	De:		Fluid ty	pe:		Fluid ty	pe:		IV inputs (all IVs)	s)	Description/BF code	<sup>T</sup> Enteral feeds checked	pH check	Oral	Other: (e.g. NG)	oral/ enteral input	Total prog. input		Code/ colour	Vol.	Co
Time	Pres IV 1	ssure	Set rate	Amount infused	Prog. total	Set rate	Amount infused	Prog. total	Set rate	Amount infused	Prog. total	(A)	Time		Dy:	oncort			(B)	(A+B)	Time			
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RTH

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Outp	Balance					
Sto	ol	Vomit/A	spirate	Other:		
ode/ blour	Vol.	Code/ colour	Vol.	Tota prog outpu (C)		Progressive Balance (A + B) – C I = incomplete balance
escrib	ed?					

 Input Routes\*

 Oral (0)
 Nasogastric (NG)
 Orojejunal (OJ)
 Gastrostomy (Gast) includes PEG

 Orogastric (OG)
 Nasojejunal (NJ)
 Jejunostomy (Jej)
 Bottle (B)

 Breast Feed (BF)
 Expressed Breast Milk (EBM)
 Breastfeeding: Refer to your local procedures/codes

Output Codes^ Where possible and relevant, weigh all nappies pre and post void. If blood present, describe volume, consistency and colour

Urine		Stool	Vomit / Aspirate					
Method		Description	Description					
Wet nappy (WN) Passed urine (PU) In-dwelling catheter (IDC) Not sighted (NS) Specific gravity (SG)	Meconium (Mec) Transition (T) Curds (C) Seedy (S) Bowels open (BO)	Formed (F) Pebbles (P) Loose (L)	Watery (W) Melaena (Mel) Not sighted (NS)	Mixed food (MF) Mucousy (Mu) Milky (M) Coffee grounds (CG) Projectile (P) Watery (W)				
Colour								
Clear/Pale Cloudy Yellow	Dark yellow / Gree Mustard	en (Bile) Dark Gr (Bile	reen Brown Pi	nk / Rosé Red (Blood) Black				

## For scanning purposes

a daamii yaafadaa										
PATIENT NAME:		DATE OF BIRTH:	UR NUMBER:							
Urinalysis: Include date and time										

**Circulating Blood Volume** To assist in estimating total blood loss (*Hazinski 2013*)

Neonate: 80-85 mL/kg Infant: 75-80 mL/kg	Child: 70–75 mL/kg	Adolescent: 65-70 mL/kg
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In patients less than 20kg calculate the transfusion volume based on weight. Refer to National Blood Authority. Patient Blood Management Guidelines Module 6: Paediatrics and Neonates 2016. https://www.blood.gov.au/pbm-module-6

burns (severe)

– cardiac failure

diabetes

head injury

hypernatraemic

dehydration

## **Escalation to a Senior Clinician Required When:**

- Electrolytes are outside the normal range
- >10% dehydration/10% weight gain or weight loss
- The need for rapid IV rehydration (e.g. over 4 hours or requiring 40 mL/kg bolus)
- Urine output of < 1mL /kg/hr
- Vomit/Aspirate that is coloured green, brown or blood stained
- Ongoing fluid losses
- Any other concerns about fluid requirements

- Conditions where fluid balance is complex and critical, for example:

metabolic disorders

hyponatraemia

ketoacidosis

- meningitis

- neonates

- acute abdominal pain hyperkalaemia renal insufficiency
  - or kidney disease
  - sepsis
  - syndrome of inappropriate antidiuretic
  - hormone (SIADH)
- If the neonate/child's condition is deteriorating, or not improving, consider more frequent reviews of electrolytes and fluid requirements