Policy Compliance Procedure

ACUTE MANAGEMENT OF INFANTS AND CHILDREN WITH CROUP

This PCP relates to

NSW Health PD	*NSW PD 2005 –392: Children and Infants with Croup – Acute Management*
PCP number	*NSW PD 2005 –392:PCP 1 Acute management of infants and children with croup*
Sites where PCP applies	Hunter New England (HNE) Northern Rural Referral Hospitals Emergency Departments (ED)
Target audience	Clinicians in ED where infants and children present with cough, inspiratory stridor and shortness of breath.
Description	Provides evidence based practice guidelines for the treatment of infants and children with croup
Subject	Acute management of croup in children
Keywords	Acute, management, croup, children, infants

Related Legislation (including OHS legislation), Australian Standards, NSW Health Policy or Circular, other HNEH Documents, Professional Guidelines, Codes of Practice or Ethics:

NSW Health Paediatric Clinical Practice Guidelines

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Summary This PCP

- is a clinical pathway in the assessment of the severity and management of croup in infants and children,
- provides guidelines on appropriate disposition, transfer/retrieval based on clinical assessment and response to treatment or discharge planning
- PCP includes relevant fact sheet for parent information.

Distribution:	GENERAL MANAGER, DON, PAEDIATRICIAN, NUM ED, ED PHYSICIAN, DIRECTOR OF MEDICAL SERVICES, CHILDREN YOUNG PEOPLE & FAMILY CLINICAL NETWORK (CYP&FCN) STREAM LEADERS
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PCP authorised by:	Professor Trish Davidson - Clinical Leader CYP&FCN
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Hunter New England Area Health Service

ACUTE MANAGEMENT OF PAEDIATRIC CROUP

Referral Hospital

Name:	
D.O.B	
MRN	

1. ASSESS SEVERITY OF AIRWAY OBSTRUCTION

	MILD	MODERATE Any one = moderate	SEVERE Any one = severe Notify senior Dr. immediately
Stridor	☐ None or intermittent	☐ Persisting stridor at rest	☐ Persisting at rest
Respiratory Distress	☐ Nil or mild chest recession ☐ Barking Cough	☐ Some tracheal tug and chest wall recession	☐ Marked tracheal tug and chest wall recession
Cyanosis	☐ Nil	☐ Nil	☐ Yes ☐ Marked Pallor
Level of Consciousness	☐ Normal	☐ Can be placated, still interested in surroundings	☐ Increasing tiredness and exhaustion ☐ Restless, agitated, irrational behaviour, hypotonia, decreased LOC
Pulse Rate	☐ Normal range for age	☐ Tachycardia	☐ Marked tachycardia ☐ Palpable paradox

Triage nurse: Severity Score ☐ Mild ☐ Moderate ☐ Severe

Signed:______________________________

Doctor: Severity Score ☐ Mild ☐ Moderate ☐ Severe

Signed:______________________________

2. MANAGEMENT

- **Child < 3 months consider structural airway problem**

	MILD	MODERATE	SEVERE
O2	Not needed	To keep sats > 95%	100% oxygen via face mask monitor vital signs **DO NOT DISTURB CHILD UNNECESSARILY**
Corticosteroids	Consider oral prednisolone (1mg/kg)	Prednisolone 1mg/kg (oral) or Nebulised Budesonide 2mg if oral steroids not tolerated. ***If no improvement*** Nebulised Adrenaline (0.5 mls/kg up to max. 5mls 1:1000 undiluted in nebuliser) & systemic steroids (same dose)	Nebulised Adrenaline 0.5 mls/kg up to max. 5mls 1:1000 undiluted/nebuliser Dexamethasone 0.15-0.3mg/kg IV or IM Repeat steroids in 12 hours
Disposition	• Fact Sheet • Discharge home	• Observe > 4 hours • ***If improved*** discharge when no stridor at rest with explanation and **fact sheet.** • ***If no/partial improvement*** admit – repeat oral steroids at 12 hours	• Admit • Continuous observations in critical care area for minimum 4 hours