**Paediatric Wheeze >1. Ward Round Checklist**

Patient Name:

Hospital number:

Date of Birth:

Date& Time:

Attending consultant:

Ward team:

|  |  |
| --- | --- |
| Diagnosis: | Medication |
| Observations | Examination |

**Background Asthma/Wheeze Check**

1. **Is their Asthma well controlled?**

Ask about previous admissions, ED Visits, Courses of Prednisolone, Salbutamol usage per week, days missed off school, check adherence

1. **Identify triggers**

This includes a) Aeroallergens, b) Food allergy, c) Exercise, d) Emotion e) Smoking (**complete Ice form**), f) allergic rhinitis – Examine nose. g) Eczema – Review skin

Cows milk☐, egg☐, wheat☐, tree nuts☐, peanut☐, soya☐, sesame☐, kiwi☐, fish☐, shellfish☐

1. **Plan / Take action:**

Complete discharge checklist, Consider Follow up and Medication initiation or change

Signature Designation

|  |  |  |
| --- | --- | --- |
| **N/A** | **Yes** |  |
|  |  | Discharge summary written |
|  |  | Discharge prescription written and pharmacy informed |
|  |  | Follow up appointment requested if required |

Patient Name:

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|  |  |
| --- | --- |
|  | Signature |
| Patient/parents have learnt appropriate spacer technique + leaflet given (circle if previously given) |  |
| Wheeze plan and weaning regime given and explained |  |
| Parents advised to see GP within 48 hours of discharge |  |
| Peak Flow & Symptom diary given (if required) |  |

**Discharge Checklist**

**The following medical checklist must be completed for a patient to be eligible for criteria led discharge:**

|  |  |  |
| --- | --- | --- |
| **Criteria for discharge** | Criteria Met  Date/time | Signature |
| Reviewed by medical team within the last 24 hours |  |  |
| **Medically fit for discharge:** |  |  |
| No supplemental oxygen requirement for the last 4 hours |  |  |
| Receiving inhaled salbutamol every 4 hours |  |  |
| Tolerating oral fluids |  |  |
| Work of breathing normal |  |  |

Responsible Consultant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Order completed by (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_

**If there are any concerns, call the paediatric registrar to review the patient prior to discharge.**

**Discharge Doctor/ Nurse:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_