General Instructions

You MUST record baseline observations, including blood pressure, on admission and thereafter:

• At a frequency appropriate for the child's clinical state • Whenever staff or family members are worried about the child's clinical state

• If the child is deteriorating

Level of Consciousness should be documented using the AVPU scale, except for children receiving sedation, where a Level of Sedation score should be recorded in Additional Observations.

Select a Pain Assessment tool appropriate for the age, developmental level and clinical state of the child. Refer to Modifications — refer to your local procedure for altering the RCH clinical practice guidelines for further information.

Show the Trend: Plot the Dot–Join the Line

This chart is specifically designed to enhance the identification of trends in vital signs. It is important to look for worsening trends and report these.

When graphing observations, place a dot in the box and connect it to the previous dot with a straight line. For blood pressure use the symbols indicated on the chart. For SpO_2 write the number in the appropriate section.

Whenever an observation falls within an orange zone or purple zone, you MUST initiate the actions required for that colour, unless a modification has been made.

	· · ·	-	rther information. calling onto								
Assessme	nt of Respiratory	Distress	lote, not all respiratory assess	nent fea	tures are relevant to all conditions						
	Mild	Moderate	Sever	Severe							
Airway	Stridor on exertion/crying	Some strido	r at rest	• Stric	Stridor at rest						
Behaviour and feeding	Normal Talks in sentences	 Difficultly tail 	nittent irritability Iking/crying eding or eating	LoolUnal	 Increased irritability and/or lethargy Looks exhausted Unable to talk or cry Unable to feed or eat 						
Respiratory rate	Mildly increased	 Respiratory 	rate in orange zone	 Respiratory rate in purple zone Increased or markedly reduced respiratory rate as the child tires 							
Accessory muscle use	 Mild intercostal and suprasternal recession 	 Moderate in suprasternal Nasal flaring 	l recession		ked intercostal, suprasternal sternal recession						
Oxygen	No oxygen requirement		mia corrected by oxygen xygen requirement		oxemia may not be corrected xygen						
Other		 May have br 	rief apnoeas	• Extr	 Gasping, grunting Extreme pallor, cyanosis Increasingly frequent or prolonged apnoeas 						
FLACC Sca	ale © University of Mic	higan									
Face	0 No particular express		1 Occasional grimace or fro withdrawn, disintereste		2 Frequent to constant frown, clenched jaw, quivering chin						
Legs	0 Normal position o	r relaxed	1 Uneasy, restless, tense		2 Kicking or legs drawn up						
Activity	0 Lying quietly, norm moves eas		1 Squirming, shifting back and forth, tense	(2 Arched, rigid or jerking						
Cry	0 No cry (awake ol	2 Crying steadily, screams or sobs, frequent complaints									
Consolability	0 Content, rela	xed	1 Reassured by occasional tou hugging or "talking to". Distra		2 Difficult to console or comfort						
Wong-Bak	er FACES Pain R	ating Scale	9								
(
0 1 2 3 4 5 6 7 8 9 10 No pain Numeric rating scale Worst pain											
Level of Se	edation UMSS-Univ	ersity of Michig	gan Scoring System	ON	LY complete if sedation administered						
0 = Awake and											
			onds to verbal conversation and								
			used with tactile stimulation or	simple v	verbal command						
		le only with dee	ep or physical stimulation								
4 = Unrousable	9										

Victorian Children's **Tool for Observation** and Response

URGENT CARE

Hospital

Arrival date:

Next of kin:

/ /

Usual language spoken:

Triage category:

Triage time:

Past history:

Weight Kg:

Current medications:



UR NUMBER

FAMILY NAME GIVEN NAME ADDRESS MEDICARE NUMBER G.P. Complete all details or Arrival time: Accompanying adult(s) name an Arrival mode: Relationship: Phone nu Interpreter required: Is the patient: 🗆 Yes 🛛 No □ Aboriginal and/or □ Torres Presenting problem: Initial nursing assessment: (if required add detailed assessment in Events/Comments over page) Allergies/adverse reactions Child health record confirms immunisations are up to date: Yes No (if No refer to doct Immunisation concerns or gueries contact RCH Immunisation Centre 1300 822 924 (option 2) Blood glucose level: mmol/L Urinalysis: \Box Not measured. (BGL <3.5 or >8 = orange zone) \Box Not measured Presentation/Admission Checklist □ All baseline observations documented Hospital risk assessments co Correct name band attached Falls Pressure Beha \Box Allergy band attached \Box N/A \Box Outcomes of risk assessme \Box IV line labelled and dated \Box N/A Frequency of observations up □ Plan of care discussed with parent/caregivers □ Ward handover given to (name/designation): ____ Presentation/admission nurse: Signature:

Transfer/Discharge Checklist Date: / / Time: Transfer/discharge to: Transp Discharged in the care of: (name) If patient is in the orange or purple zones at discharge, the patient must have: Doctor/Senior clinician review and refer to your local escalation of care procedure Plan of care documented Tick relevant: Follow up arrangeme Transfer/discharge letter provided Medication(s) provided Prescription(s) given Valuables returned Plan of care discusse Transfer/discharge nurse: Signature:

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ed with parent/caregivers Time:	COD

Attach ADR stick	er	UR NUMBER									
Allergies and adverse o	wn	GIVEN NAME GIVEN NAME DOB									
Medicine (or other)	Reaction/type/date	Initials		Complete all details or affix label above							
			First prescriber to print p	patient name and che	ck label correct:						
			Weight (kg):	Height (cm):	BSA (m ²):						
Sign:	Print:	Date: / /	Date weighed:								

ONCE ONLY MEDICINES

Paediatric medication chart

If patient admitted, transfer to a NIMC — paediatric

Medications Ordered by Attending Doctor/Nurse Practitioner Date pracribed Indefinition Route Doce bit be given Prescriber graduus Prescriber prescribed Doce cale a. prescribed Even trans Prescribed Date The cord of administration (11) Oute trans Date The cord of administration (11) The cord of administration (11) <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>LDIU</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>								LDIU									
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Record event details, including comments, interventions Date/Time	Frequency of Observations Observations should be performed routinely at least ½ hourly, unless advised here. Refer to local procedure for <i>who</i> can alter frequency.	Wake patient before scoring) Pain Score □ FLACC □ Faces □ FLACC □ Faces □ see general instructions) Additional Observations (e.g. BSL, weight, capillary refinance)	Level of Consciousness	Temperature (C°) Reportable limits—if applicable, refer to local procedur Temp \geq (e.g.) 39.5 Temp \leq - Date 6/4/14 Dr 1800 Dr Smith	Date Time Dr Signature	Blood Pressure X (mmHg) systolic BP is the trigger Modifications Purple Orange Duration Duration Inswimun 2 Inst	Dr Smith Signature Smith	ModificationsPurple(e.g.) –Orange140Duration (maximum 2 hrs)2/24Date6/4/14Time1600	Heart Rate (beats/min)	Purple Purple Orange Duration Duration Date Time Time Signature Respiratory Distress (see leaged over name)	Time Dr Signature Respiratory Rate (breaths/min)	02 Saturation (%) (write value Modifications	Staff initial (<i>with</i>	Victorian Children's Tool fo
and parental concerns. Ensure you add the	Frequency Name	Pain Pain Unresponsive 8-10 4-7 1-3 Nil Observations to be plo If time, level of sedation score)	Alert Verbal	Write≥40 39.5 38.5 37.5 36.5 36.5 36.5 36.5 36.5 36.5	995 995 75 76 75 60 50 50 50	145 145 146 135 140 135 125 125 125	Write >160		Moderate Mild Nil Write≥170	Severe 10.337	Device 02 device NP = nasal prongs, HM = Hu Write ≥58 55	lue) ≥94 90–93 ≤89 02 delivery	Time Time	URGENT CARE
date, time and sign each entry.		tted with a dot and joined with a line (exce)									dson mask, HNP = humidified nasal prongs, HFNP = hig			5–11 Actual age: years
	Act	pt SpO ₂ and BP)	Alert Verbal	Write≥40 39.5 38.5 37.5 36.5 36.5 35.5	write≤45 3.0	• • • ₽	Write \$50	4. E. p. 2. 1. p. 4. E. p. 4.	Prate 9 ≥170	re la	device	≥94 90–93 ≤89	DATE	Weight: FAMI
	Actions required 1. Inform senior clinical nurse 2. Review frequency of observations 3. Consider escalation of care	 Response criteria Vital signs in the white zone but the Looks unwell Has consecutive observations trendi coloured zone 	White zone STAY VIGILANT	 and plan of care in Events/Comments Medical review Increase frequency of observations aby the child's condition If not attended within 30 minutes, exto emergency call Medical officer to document manage 	Actions required 1. Initiate appropriate clinical care 2. Consider what is usual for the child and if the trend in observations suggests deterioration 3. Consult with nurse in charge, decide if a medical review is required If no medical review document	ponse criteria taff member is worried about the family member is worried about ny observation in the orange zon	Orange zor CLINICAL REVIEW RE	 Actions required 1. Place emergency call 2. Initiate appropriate clinical care until the arrival of the emergency respondent/s 3. Emergency respondent/s to attend immediately, stabilise patient and/or provide advice 4. Emergency respondent/s to document management plan 	 Sudden decrease in conscious state Any observation in the purple zone 3 or more simultaneous orange zone or 	 Staff member is very worried about A family member is very worried ab the child's clinical state Apnoea or cyanosis Cardiac or respiratory arrest Airway threat Prolonged convulsion 	Purple zone MANDATORY EMERGENCY CALL	GENERAL ESCALATION RESPONSE You must refer to your local procedure for instructions on <i>how</i> to escalate patient care	OF BIRTH Complete all details or affix	UMBER
Name/Signature		e child is unstable ling towards either	e ANT	nments rations as indicated nutes, escalate management plan	l and if the trend ion le if a medical	child's clinical state the child's clinical state e	Orange zone REVIEW RECOMMENDED	itil the arrival immediately, stabilise nent management plan	e criteria	t the child's clinical state oout	e Gency Call	DN RESPONSE ocal procedure scalate patient care	label above	