VUC1218

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 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.

Modifications — refer to your local procedure for altering calling criteria.

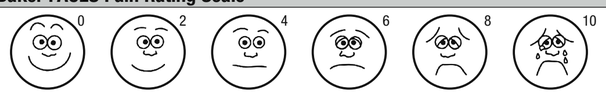
Assessment of Respiratory Distress Note, not all respiratory assessment features are relevant to all conditions

	Mild	Moderate	Severe
Airway	• Stridor on exertion/crying	• Some stridor at rest	• Stridor at rest
Behaviour and feeding	• Normal • Talks in sentences	• Some/intermittent irritability • Difficultly talking/crying • Difficultly feeding or eating	• 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 intercostal and suprasternal recession • Nasal flaring	• Marked intercostal, suprasternal and sternal recession
Oxygen	• No oxygen requirement	• Mild hypoxemia corrected by oxygen • Increasing oxygen requirement	• Hypoxemia may not be corrected by oxygen
Other		• May have brief apnoeas	• Gasping, grunting • Extreme pallor, cyanosis • Increasingly frequent or prolonged apnoeas

FLACC Scale © University of Michigan

Face	**0** No particular expression or smile	**1** Occasional grimace or frown, withdrawn, disinterested	**2** Frequent to constant frown, clenched jaw, quivering chin
Legs	**0** Normal position or relaxed	**1** Uneasy, restless, tense	**2** Kicking or legs drawn up
Activity	**0** Lying quietly, normal position, moves easily	**1** Squirming, shifting back and forth, tense	**2** Arched, rigid or jerking
Cry	**0** No cry (awake or asleep)	**1** Moans or whimpers occasional complaints	**2** Crying steadily, screams or sobs, frequent complaints
Consolability	**0** Content, relaxed	**1** Reassured by occasional touching, hugging or "talking to". Distractable	**2** Difficult to console or comfort

Wong-Baker FACES Pain Rating Scale



Level of Sedation UMSS – University of Michigan Sedation Scoring System

ONLY complete if sedation administered

0 = Awake and alert
1 = Minimally sedated: may appear tired/sleepy, responds to verbal conversation and/or sound
2 = Moderately sedated: somnolent/sleeping, easily roused with tactile stimulation or simple verbal command
3 = Deep sedation: deep sleep, rousable only with deep or physical stimulation
4 = Unrousable

Victorian Children's Tool for Observation and Response

12–18 years

URGENT CARE

UR NUMBER _____ DOB _____
FAMILY NAME _____ SEX _____
GIVEN NAME _____
ADDRESS _____
MEDICARE NUMBER _____
G.P. _____
Complete all details or affix label above

Hospital _____

Arrival date: / /	Arrival time:	Arrival mode:	Accompanying adult(s) name and relationship to patient:

Next of kin:	Relationship:	Phone number:

Usual language spoken:	Interpreter required: ☐ Yes ☐ No	Is the patient: ☐ Aboriginal and/or ☐ Torres Strait Islander

Triage category:	Presenting problem:
Triage time:	

Initial nursing assessment: (*if required add detailed assessment in Events/Comments over page*)

Past history:

Current medications:	Allergies/adverse reactions:

Child health record confirms immunisations are up to date: ☐ Yes ☐ No (if No refer to doctor or nurse immuniser)
Immunisation concerns or queries contact RCH Immunisation Centre 1300 822 924 (option 2)

Weight Kg:	Blood glucose level: mmol/L ☐ Not measured. *(BGL <3.5 or >8 = orange zone)*	Urinalysis: ☐ Not measured

Presentation/Admission Checklist

- ☐ All baseline observations documented
- ☐ Correct name band attached
- ☐ Allergy band attached ☐ N/A
- ☐ IV line labelled and dated ☐ N/A
- ☐ Plan of care discussed with parent/caregivers
- ☐ Hospital risk assessments completed (circle relevant): Falls Pressure Behavioural Other
- ☐ Outcomes of risk assessment(s) actioned ☐ N/A
- ☐ Frequency of observations updated for ward transfer ☐ N/A
- ☐ Ward handover given to (name/designation): _____ ☐ N/A

Presentation/admission nurse:	Signature:	Time:

Transfer/Discharge Checklist

Date: / /	Time:	Transfer/discharge to:	Transport mode:

Discharged in the care of: (name) (relationship)

If patient is in the orange or purple zones at discharge, the patient must have:
☐ Doctor/Senior clinician review *and* ☐ Plan of care documented — refer to your local escalation of care procedure

Tick relevant:
☐ Transfer/discharge letter provided ☐ Medication(s) provided ☐ Follow up arrangements communicated
☐ Prescription(s) given ☐ Valuables returned ☐ Plan of care discussed with parent/caregivers

Transfer/discharge nurse:	Signature:	Time:

Victorian Children's Tool for Observation and Response (12–18 years) VUC1218

Attach ADR sticker

Allergies and adverse drug reactions (ADR)
☐ Nil known ☐ Unknown
(tick appropriate box or complete details below)

Medicine (or other)	Reaction/type/date	Initials
Sign:	Print:	Date: / /

UR NUMBER _____
FAMILY NAME _____
GIVEN NAME _____
DOB _____ SEX _____
Complete all details or affix label above

First prescriber to print patient name and check label correct:

Weight (kg):	Height (cm):	BSA (m^2):
Date weighed:		

Paediatric medication chart — **If patient admitted, transfer to a NIMC — paediatric**

ONCE ONLY MEDICINES

Medications Ordered by Attending Doctor/Nurse Practitioner

Date prescribed	Medicine (print generic name)	Route	Dose	Date/time to be given	Prescriber Signature	Prescriber Print name	Dose calc e.g. mg/kg per dose	Given by	Date/time given	Pharm

Telephone Orders (to be signed within 24 hours of order)

Date time	Medicine (print generic name)	Route	Dose	Frequency	Clinicians initials Cl 1	Clinicians initials Cl 2	Prescriber name	Prescriber sign	Date	Record of administration Time/ given by	Time/ given by	Time/ given by	Time/ given by

Medications Administered by Nurse with Scheduled Medicines (Rural & Isolated Practice) Endorsement

Date prescribed	Medicine (print generic name)	Route	Dose	Date/time to be given	Health management protocol	Dose calc e.g. mg/kg per dose	Given by	Date/time given	Pharm

Nurse Initiated Medications

Date prescribed	Medicine (print generic name)	Route	Dose	Date/time to be given	Nurse initiator Signature	Nurse initiator Print name	Dose calc e.g. mg/kg per dose	Given by	Date/time given	Pharm

Medications Taken Prior to Presentation at Hospital (prescribed, over the counter, complementary) Own medicines brought in: ☐ Yes ☐ No

Medicine & formulation	Dose & frequency	Duration	Medicine & formulation	Dose & frequency	Duration
Doctor/G.P.:			Community pharmacy:		
Sign:	Print:	Date:	Medicines usually administered by:		

Not for Administration

Drill holes where indicated by die cut colour. Do not print.

ERC 150838 November 2015

Victorian Children's Tool for Observation and Response URGENT CARE

12–18 years

Actual age:

Weight:

AFFIX PATIENT LABEL OVER PAGE

UR NUMBER

FAMILY NAME

GIVEN NAME

DATE OF BIRTH

Complete all details or affix label above

		Date
		Time
		Staff initial *(with each set of obs)*

O2 Saturation (%) *(write value)*

Modifications

Purple	
Orange	
Duration *(maximum 2 hrs)*	
Date	
Time	
Dr	
Signature	

≥94 / 90–93 / ≤89 / O_2 delivery L/min or % / Device / O_2 device

NP = nasal prongs, HM = Hudson mask, HNP = humidified nasal prongs, HFNP = high flow nasal prongs

Respiratory Rate (breaths/min)

Modifications

Purple	
Orange	
Duration *(maximum 2 hrs)*	
Date	
Time	
Dr	
Signature	

Write ≥40 / 38 / 36 / 34 / 32 / 30 / 28 / 26 / 24 / 22 / 20 / 18 / 16 / 14 / 12 / 10 / 8

Respiratory Distress *(see legend over page)*

Severe / Moderate / Mild / Nil

Heart Rate (beats/min)

Modifications

	(e.g.)	
Purple	–	
Orange	125	
Duration *(maximum 2 hrs)*	2/24	
Date	6/4/14	
Time	1600	
Dr	Smith	
Signature	Smith	

Write ≥160 / 155 / 150 / 145 / 140 / 135 / 130 / 125 / 120 / 115 / 110 / 105 / 100 / 95 / 90 / 85 / 80 / 75 / 70 / 65 / 60 / 55 / 50 / 45 / Write ≤40

Blood Pressure (mmHg) systolic BP is the trigger

Modifications

Purple	
Orange	
Duration *(maximum 2 hrs)*	
Date	
Time	
Dr	
Signature	

Write ≥170 / 165 / 160 / 155 / 150 / 145 / 140 / 135 / 130 / 125 / 120 / 115 / 110 / 105 / 100 / 95 / 90 / 85 / 80 / 75 / 70 / 65 / 60 / Write ≤55

Temperature (C°)

Reportable limits—if applicable, refer to local procedures

	(e.g.)	
Temp ≥	39.5	
Temp ≤	–	
Date	6/4/14	
Time	1800	
Dr	Smith	
Signature	Smith	

Write ≥40 / 39.5 / 39 / 38.5 / 38 / 37.5 / 37 / 36.5 / 36 / 35.5 / 35

Level of Consciousness

(wake patient before scoring)

Alert / Verbal / Pain / Unresponsive

Pain Score

☐ FLACC ☐ Faces ☐ Numeric *(please tick tool)*

(see general instructions)

8–10 / 4–7 / 1–3 / Nil

Observations to be plotted with a dot and joined with a line (except SpO_2 and BP)

Additional Observations *(e.g. BSL, weight, capillary refill time, level of sedation score)*

Frequency of Observations Observations should be performed routinely at least ½ hourly, unless advised here. Refer to local procedure for *who* can alter frequency.

Date / Frequency / Name

Events/Comments

Record event details, including comments, interventions and parental concerns. Ensure you add the date, time and sign each entry.

Date/Time		Name/Signature

GENERAL ESCALATION RESPONSE

You must refer to your local procedure for instructions on *how* to escalate patient care

Purple zone
MANDATORY EMERGENCY CALL

Response criteria

- Staff member is very worried about the child's clinical state
- A family member is very worried about the child's clinical state
- Apnoea or cyanosis
- Cardiac or respiratory arrest
- Airway threat
- Prolonged convulsion
- Sudden decrease in conscious state
- Any observation in the purple zone
- 3 or more simultaneous orange zone criteria

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

Orange zone
CLINICAL REVIEW RECOMMENDED

Response criteria

- Staff member is worried about the child's clinical state
- A family member is worried about the child's clinical state
- Any observation in the orange zone

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 rationale and plan of care in Events/Comments
4. Medical review
   - Increase frequency of observations as indicated by the child's condition
   - If not attended within 30 minutes, escalate to emergency call
   - Medical officer to document management plan

White zone
STAY VIGILANT

Response criteria

- Vital signs in the white zone but the child is unstable
- Looks unwell
- Has consecutive observations trending towards either coloured zone

Actions required

1. Inform senior clinical nurse
2. Review frequency of observations
3. Consider escalation of care