Victorian Children's Tool for Observation and Response

3–12 mths

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Hospital _____

Frequency of Observations

Observations should be performed routinely at least 4 hourly, unless advised below — Refer to local procedure for ***who*** can alter frequency

Date	(e.g.) 6/4/14						
Frequency	2/24						
Name/Designation	Smith RN						

Events/Comments

Record event details, including comments, interventions and parental concerns

	Date	Time		Initial	Designation
A					
B					
C					
D					
E					
F					
G					
H					

O_2 Device NP = nasal prongs, HM = Hudson mask, HNP = humidified nasal prongs, HFNP = high flow nasal prongs

Assessment of Respiratory Distress

	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

Note, not all respiratory assessment features are relevant to all conditions

Victorian Children's Tool for Observation and Response (3–12 months) VP031

Refer to your local procedure for instructions on ***how*** to call for assistance and escalate care

MANDATORY EMERGENCY CALL

Choose MET or other Code response

Response criteria

- 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
- Staff member is very worried about the child's clinical state
- A family member is very worried about the child's clinical state

Actions required

1. Place emergency call
2. Initiate appropriate clinical care until the arrival of the emergency response team
3. Emergency response team to attend immediately, stabilise patient and/or provide advice
4. Emergency response team to document management plan

CLINICAL REVIEW RECOMMENDED

Response criteria

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

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

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

OR

4. No medical review

- Document rationale & plan of care in Events/Comments

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.

Select a Pain Assessment tool appropriate for the age, developmental level and clinical state of the child. Refer to the website and/or the RCH clinical practice guidelines for pain tools.

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 local procedure for altering calling criteria.

Level of Sedation (UMSS – University of Michigan 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

State Government Victoria

The ViCTOR project is supported by the Victorian Government

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

AFFIX PATIENT LABEL OVER PAGE

Victorian Children's Tool for Observation and Response

3–12 mths

Actual age: | **Weight:**

Surname: | **Given name:** | **UR:**

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

O_2 Saturation (%)

(write value)

Modifications

Purple			
Orange			
Duration *(maximum 24 hrs)*			
Date			
Time			
Dr			
Signature			

≥94 | 90–93 | ≤89 | O_2 delivery L/min or % | Device | Probe change

Respiratory Rate (breaths/min)

Modifications

Purple			
Orange			
Duration *(maximum 24 hrs)*			
Date			
Time			
Dr			
Signature			

Write ≥95 | 90 | 85 | 80 | 75 | 70 | 65 | 60 | 55 | 50 | 45 | 40 | 35 | 30 | 25 | 20 | 15

Respiratory Distress *(see legend over page)*

Severe | Moderate | Mild | Nil

Heart Rate (beats/min)

Modifications

Purple	(e.g.) 185			
Orange	170			
Duration *(maximum 24 hrs)*	4/24			
Date	6/4/14			
Time	1600			
Dr	Smith			
Signature	Smith			

Write ≥200 | 195 | 190 | 185 | 180 | 175 | 170 | 165 | 160 | 155 | 150 | 145 | 140 | 135 | 130 | 125 | 120 | 115 | 110 | 105 | 100 | 95 | 90 | 85 | Write ≤80

Blood Pressure (mmHg) systolic BP is the trigger

Modifications

Purple			
Orange			
Duration *(maximum 24 hrs)*			
Date			
Time			
Dr			
Signature			

Write ≥145 | 140 | 135 | 130 | 125 | 120 | 115 | 110 | 105 | 100 | 95 | 90 | 85 | 80 | 75 | 70 | 65 | 60 | 55 | 50 | 45 | 40 | 35 | Write ≤30

Temperature (C°)

Reportable limits — if applicable, refer to local procedures

Temp ≥	(e.g.) 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

Level of Sedation *(ONLY complete if sedation administered)*

(wake patient before scoring; see legend on back page)

0 | 1 | 2 | 3 | 4

Pain Score

Refer to FLACC scale

(see general instructions)

8–10 | 4–7 | 1–3 | Nil

Additional Observations *(e.g. BSL, weight, capillary refill time)*

Events/Comments *(e.g. **A**; see over page)*

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