VBPN010

Victorian Children's Tool for Observation and Response

Birth/ PN

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Hospital _____

Birth Details

Date of birth: / /	Time of birth:	Type of birth:
Birth weight:	Gestation:	Sex:
Head circumference:	Length:	
Apgar scores at 1 min:	5 min:	10 min:
Resuscitation at birth: ☐ Nil ☐ Tactile stimulation ☐ Oxygen ☐ CPAP ☐ IPPV ☐ Other _____		

Modifications *(refer to your local procedure for site specific instructions)*

Modification instructions

1. Modifications should only be completed by a doctor or nurse practitioner.

2. Only one orange zone observation can be modified. No purple zones should be modified.

3. The first modification is for a maximum duration of 4 hours. Subsequent modification(s) (> 4 hours), the maximum duration is 24 hours.

4. Justify modification in the Events/Comments area.

5. Consider escalating care to special care nursery or contacting PIPER 1300 137 650.

	Example	**Modification 1:** maximum duration up to 4 hours	**Subsequent modification(s):** maximum duration up to 24 hours	
Date	10/07/17			
Time	1300			
New orange zone (parameter & value)	RR > 65			
Modification duration	2 hours			
Review due time	1500			
Doctor name	J Smith			
Doctor signature	*J Smith*			

Events/Comments

Record event details, including comments, interventions and family/carer concerns

	Date	Time		Initial	Designation
A					
B					
C					
D					
E					
F					

Victorian Children's Tool for Observation and Response (Birth Suite/PN) VBPN010

GENERAL ESCALATION RESPONSE. You must refer to your local procedure for instructions on ***how*** to call for assistance and escalate care

Purple Zone — MANDATORY EMERGENCY CALL

Response criteria
- Staff member is very worried about the newborn's clinical state
- A family member is very worried about the newborn's clinical state
- Central cyanosis
- Cardiac or respiratory arrest
- Airway threat
- Seizure
- 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 newborn 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 newborn's clinical state
- A family member is worried about the newborn's clinical state
- Any observation in the orange zone
- Bile stained vomit
- Lack of interest in feeding (> 24 hours of age)

Actions required
1. Initiate appropriate clinical care
2. Consider what is usual for the newborn and if the trend in observations suggests deterioration
3. Consult with nurse/midwife in charge, decide if a medical review is required. If no medical review, document rationale and plan of care in Events/Comments

4. If medical review requested
- Increase frequency of observations as indicated by the newborn'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 newborn is unstable
- Looks unwell
- Has consecutive observations trending towards either coloured zone

Actions required
1. Inform senior clinical midwife/nurse
2. Review frequency of observations
3. Consider escalation of care

Assessment of Respiratory Effort

	Mild	Moderate	Severe
Airway		• Stridor on crying	• Stridor at rest
Behaviour and Feeding	• Normal	• Some/intermittent irritability • Difficulty crying • Difficulty feeding (dependent on gestational age)	• Increased irritability and/or lethargy • Looks exhausted • Unable to cry • Unable to feed (dependent on gestational age)
Respiratory Rate	• Mildly increased	• Respiratory rate in orange zone	• Respiratory rate in purple zone • Increased or markedly reduced respiratory rate as the newborn tires
Accessory Muscle Use	• Mild intercostal and suprasternal recession	• Nasal flaring • Moderate intercostal and suprasternal recession	• Marked intercostal, suprasternal and sternal recession
Oxygen	• No oxygen requirement	• Mild hypoxaemia corrected by oxygen • Increasing oxygen requirement	• Hypoxaemia may not be corrected by oxygen
Apnoeas		• May have multiple brief apnoeas (< 20 secs)	• Increasingly frequent or prolonged apnoeas (> 20 secs)
Other			• Gasping, grunting • Extreme pallor, cyanosis

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

170087 March 2024

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

Victorian Children's Tool for Observation and Response

Birth Suite/Postnatal

UR NUMBER _____

FAMILY NAME _____

GIVEN NAME _____

DATE OF BIRTH _____

Complete all details or affix label above

INSTRUCTIONS:
1. Complete a full set of observations and the Newborn Risk Assessment within the 1st hour of life.
2. Continue observations hourly for a further 3 hours.
3. Continue once a shift for 48 hours or until hospital discharge (whichever occurs earlier) then as per hospital procedure.
4. If Newborn risks are identified, refer to your local procedures for the frequency and duration of observations.

Any time the baby is deteriorating, or the parent(s) is concerned, increase frequency of observations appropriate to the newborn's clinical state.

Date					
Observations	1st hr	2nd hr	3rd hr	4th hr	Ongoing observations
Staff initial (with each set of obs)					
Time of observations					
Cord clamp secured					

Family/ Carer Concern
Are you worried your child is getting worse?
Please record reason for concern in the Events/ Comments section. Record as 'U' if a family member or carer is unavailable.

Yes ☐ No ☐

Respiratory Rate (breaths/min)

Write ≥ 100 / 95 / 90 / 85 / 80 / 75 / 70 / 65 / 60 / 55 / 50 / 45 / 40 / 35 / 30 / 25 / Write ≤ 20

Respiratory Effort *(see legend over page)*

Severe / Moderate / Mild / Normal

Heart Rate (beats/min)

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

Colour

Pink/normal / Pallor / Mottled / Cyanosed

Jaundice Onset

< 24 hours = purple zone | > 24 hours = white zone | Refer to local procedure. Document in Events/Comments

Temperature (°C) write value

≥ 38.1 / 37.6–38 / 36.5–37.5 / 35.5–36.4 / ≤ 35.4

Level of Activity

Settled/sleeping / Alert / Jittery / Irritable / Lethargic / Unresponsive

Additional Observations *(e.g. cord condition, SpO_2, muscle tone, time feed given)*

Events/Comments *(e.g. A—see over)*

Only Complete Below Observations if Relevant Risks Identified

Blood Glucose Level (mmol/L) Write value

Only complete if baby at risk of hypoglycaemia

≥ 2.6 / 1.5 – 2.5 / ≤ 1.4

Newborn Scalp Check

Only complete if vacuum, forceps or unsuccessful instrumental birth. You must inspect and palpate the scalp.

No bruising or swelling / Caput succedaneum / Cephalohaematoma / Increasing swelling / Fluctuant boggy mass

Newborn Risk Assessment*

Complete with birth observations.

Refer to your local procedure for observation frequency and duration.

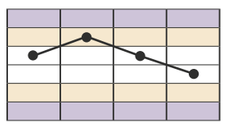
Risk	Reason *(tick all appropriate)*
Preterm ☐ No risk	☐ < 37 weeks
Respiratory Distress/ Depression ☐ No risk	☐ Apgar score < 7 at 5 minutes ☐ Cord pH < 7.1 ☐ Raised cord lactate (refer to your local procedure) ☐ Meconium stained liquor ☐ Maternal opiates for pain relief < 4 hours prior to birth ☐ Maternal general anaesthetic ☐ Newborn Naloxone use
Sepsis ☐ No risk	☐ Maternal rupture of membranes ≥ 18 hours ☐ Maternal fever ≥ 38 °C ☐ A previous sibling with GBS infection ☐ Known carriage of maternal GBS in current pregnancy (refer to local procedure) ☐ Clinical diagnosis of maternal chorioamnionitis ☐ Twin with suspected sepsis
Jaundice ☐ No risk	☐ Blood group incompatibility or known maternal antibodies ☐ Family history of G6PD or severe jaundice in the newborn ☐ Bruising
Hypoglycaemia ☐ No risk	☐ Maternal diabetes ☐ Birth Weight < 2.5 kg ☐ Small for gestational age (< 10th centile) ☐ Large for gestational age (> 90th centile) ☐ Macrosomia (≥ 4.5kg)
Birth Trauma ☐ No risk	☐ Vacuum/forceps/unsuccessful instrumental birth **DO NOT USE A HAT/BEANIE** ☐ Any trauma related to birth
Neonatal Abstinence ☐ No risk	☐ Maternal drug and/or alcohol use
Other	☐ _____

* Adapted with permission from the Clinical Excellence Commission's NSW Health Standard Newborn Observation Chart

Join the Dot—Show the Trend

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 Temperature and Blood Glucose Level, write the number in the appropriate section.



Saturation (SpO_2) Screen—Postductal (foot) Prior to Discharge *(write value)*

Screening should be performed prior to discharge but can be undertaken as early as 4 hours and up to 48 hours. Ideally screening is performed 24 hours after birth.

Date & time	/ / :	
Foot (circle)	L R	
SpO_2		
Escalation	Orange: 94% – 90%	Purple: ≤ 89%
Clinician name		
Signature		