

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

1-4
years

**UR NUMBER** 

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

Hospital

AFFIX PATIENT LABEL HERE ↑

Fre	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.) <b>6/4/25</b>							
Freq	uency		2/24							
Name/Designation		Smith RN								
Eve	<b>Events/Comments</b>									
Record event details, including comments, interventions and parental concerns										
	Date	Time							Initial	Designation

	Date	Time	Initial	Designation
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**O<sub>2</sub> 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

# 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

### 0R

#### 4. No medical review

• Document rationale & plan of care in Events/Comments

## **General Instructions**

Victorian Children's Tool for Observation and Response

(1-4 years) VP0014

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 quidelines 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<sub>2</sub> 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.

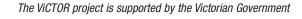
Modifications—refer to your local procedure for altering calling criteria.

#### **Level of Sedation** (UMSS-University of Michigan Scoring System)

ONLY complete if sedation administered

- 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









# AFFIX PATIENT LABEL OVER PAGE 0<sub>2</sub> delivery L/min or % Device Probe change 90-93 ≥94 88≥ Given name: Surname: ä Actual age: Weight: 1-4 years 0<sub>2</sub> delivery L/min or % Device Probe change 39.5 38.5 38.5 37.5 37.5 36.5 36.5 35.5 ≥94 Staff initial (with each set of obs) Victorian Children's Tool for **Observation and Response** refer to local procedure **Blood Pressure** $\stackrel{\textstyle extstyle \times}{ imes}$ (mmHg) systolic BP is the trigger Respiratory Distress (see legend over page) Family/ Carer Concern Are you worried your child is getting worse? Please record reason for concern in the Events/Comm Record as 'U' if a family member or carer is unavailab Respiratory Rate (breaths/min) Reportable limits—if applicable, re (e.g.) Temp ≥ (e.g.) 39.5 Additional Observations eEvents/Comments (e.g. A; Heart Rate (beats/min) evel of Consciousness Level of Sedation (ONLY **0<sub>2</sub> Saturation (%)**Modifications 6/4/25 1800 Smith Smith 6/4/25 1600 Smith (C°) 4/24 (e.g.) 155 Pain Score □ FLACC □ Faces Duration (maximum 24 hrs) Modifications Purple Date Time