

VUC511

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 SpO₂ 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 • Difficulty talking/crying • Difficulty 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

0

2

4

6

8

10

0

1

2

3

4

5

6

7

8

9

10

No pain

Numeric rating scale

Worst pain

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	

Victorian Children’s Tool for Observation and Response

URGENT CARE

5–11 years

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

Urinalysis:

☐ Not measured. *(BGL <3.5 or >8 = orange zone)*

☐ 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
☐ Prescription(s) given

☐ Medication(s) provided
☐ Valuables returned

☐ Follow up arrangements communicated
☐ Plan of care discussed with parent/caregivers

Transfer/discharge nurse:

Signature:

Time:

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 (m²):

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 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:

