



Victorian Children’s
Tool for Observation
and Response

12–18
years

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
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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 (12–18 years) VP01218

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 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 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



The ViCTOR project is supported by the Victorian Government

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

Victorian Children's Tool for Observation and Response

12-18 years

Actual age:

Weight:

Surname:

UR=

Given name:

[illegible]

Respiratory Rate (breaths/min)

Modifications

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

Write ≥ 40 [illegible]

Respiratory Distress (see legend over page)

Respiratory Distress (see legend over page)

Heart Rate (beats/min)

Write ≥ 160

Modifications			
Purple	(e.g.) 140		
Orange	125		
Duration <i>(maximum 24 hrs)</i>	4 / 24		
Date	6/4/14		
Time	1600		
Dr	Smith		
Signature	<i>Smith</i>		

Write ≥ 160

White ≤40	White 41-60	White 61-80	White 81-100	White 101-120	White 121-140	White 141-160	White 161-180	White 181-200	White 201-220	White 221-240	White 241-260	White 261-280	White 281-300	White 301-320	White 321-340	White 341-360	White 361-380	White 381-400	White 401-420	White 421-440	White 441-460	White 461-480	White 481-500	White 501-520	White 521-540	White 541-560	White 561-580	White 581-600	White 601-620	White 621-640	White 641-660	White 661-680	White 681-700	White 701-720	White 721-740	White 741-760	White 761-780	White 781-800	White 801-820	White 821-840	White 841-860	White 861-880	White 881-900	White 901-920	White 921-940	White 941-960	White 961-980	White 981-1000	White 1001-1020	White 1021-1040	White 1041-1060	White 1061-1080	White 1081-1100	White 1101-1120	White 1121-1140	White 1141-1160	White 1161-1180	White 1181-1200	White 1201-1220	White 1221-1240	White 1241-1260	White 1261-1280	White 1281-1300	White 1301-1320	White 1321-1340	White 1341-1360	White 1361-1380	White 1381-1400	White 1401-1420	White 1421-1440	White 1441-1460	White 1461-1480	White 1481-1500	White 1501-1520	White 1521-1540	White 1541-1560	White 1561-1580	White 1581-1600	White 1601-1620	White 1621-1640	White 1641-1660	White 1661-1680	White 1681-1700	White 1701-1720	White 1721-1740	White 1741-1760	White 1761-1780	White 1781-1800	White 1801-1820	White 1821-1840	White 1841-1860	White 1861-1880	White 1881-1900	White 1901-1920	White 1921-1940	White 1941-1960	White 1961-1980	White 1981-2000	White 2001-2020	White 2021-2040	White 2041-2060	White 2061-2080	White 2081-2100	White 2101-2120	White 2121-2140	White 2141-2160	White 2161-2180	White 2181-2200	White 2201-2220	White 2221-2240	White 2241-2260	White 2261-2280	White 2281-2300	White 2301-2320	White 2321-2340	White 2341-2360	White 2361-2380	White 2381-2400	White 2401-2420	White 2421-2440	White 2441-2460	White 2461-2480	White 2481-2500	White 2501-2520	White 2521-2540	White 2541-2560	White 2561-2580	White 2581-2600	White 2601-2620	White 2621-2640	White 2641-2660	White 2661-2680	White 2681-2700	White 2701-2720	White 2721-2740	White 2741-2760	White 2761-2780	White 2781-2800	White 2801-2820	White 2821-2840	White 2841-2860	White 2861-2880	White 2881-2900	White 2901-2920	White 2921-2940	White 2941-2960	White 2961-2980	White 2981-3000	White 3001-3020	White 3021-3040	White 3041-3060	White 3061-3080	White 3081-3100	White 3101-3120	White 3121-3140	White 3141-3160	White 3161-3180	White 3181-3200	White 3201-3220	White 3221-3240	White 3241-3260	White 3261-3280	White 3281-3300	White 3301-3320	White 3321-3340	White 3341-3360	White 3361-3380	White 3381-3400	White 3401-3420	White 3421-3440	White 3441-3460	White 3461-3480	White 3481-3500	White 3501-3520	White 3521-3540	White 3541-3560	White 3561-3580	White 3581-3600	White 3601-3620	White 3621-3640	White 3641-3660	White 3661-3680	White 3681-3700	White 3701-3720	White 3721-3740	White 3741-3760	White 3761-3780	White 3781-3800	White 3801-3820	White 3821-3840	White 3841-3860	White 3861-3880	White 3881-3900	White 3901-3920	White 3921-3940	White 3941-3960	White 3961-3980	White 3981-4000	White 4001-4020	White 4021-4040	White 4041-4060	White 4061-4080	White 4081-4100	White 4101-4120	White 4121-4140	White 4141-4160	White 4161-4180	White 4181-4200	White 4201-4220	White 4221-4240	White 4241-4260	White 4261-4280	White 4281-4300	White 4301-4320	White 4321-4340	White 4341-4360	White 4361-4380	White 4381-4400	White 4401-4420	White 4421-4440	White 4441-4460	White 4461-4480	White 4481-4500	White 4501-4520	White 4521-4540	White 4541-4560	White 4561-4580	White 4581-4600	White 4601-4620	White 4621-4640	White 4641-4660	White 4661-4680	White 4681-4700	White 4701-4720	White 4721-4740	White 4741-4760	White 4761-4780	White 4781-4800	White 4801-4820	White 4821-4840	White 4841-4860	White 4861-4880	White 4881-4900	White 4901-4920	White 4921-4940	White 4941-
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Blood Pressure \times (mmHg) systolic BP is the trigger

165

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

165

	Write >= 55	Write < 55
160		
155		
150		
145		
140		
135		
130		
125		
120		
115		
110		
105		
100		
95		
90		
85		
80		
75		
70		
65		
60		

Temperature (C°)

Reportable limits—if applicable, refer to local procedures

Temp \geq	(e.g.) 39.5			
Temp \leq	-			
Date	6/4/14			
Time	1800			
Dr	Smith			
Signature	<i>Smith</i>			

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

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

(see general instructions)

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

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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)