trim when printed on A3 paper

ACT **Health**

GENERAL OBSERVATION CHART PAEDIATRIC

1 - 4 YEARS

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Alteration to calling criteria. **Document reason for Alteration to calling criteria below and urgent review parameters over page. Patient must be reviewed within 24 hours (earlier if clinically indicated). Registrar can document Alteration after discussing with Consultant. Consultant to sign below within 24 hours. If further Alteration to calling criteria required commence new chart.**	
Date/Time:	
Reason for Alteration:	
Next review date/time: (not > than 24 hours)	
Observation frequency:	
Alteration to calling criteria documented over page?	☐ **Yes** ☐ **No**
Additional instructions and/ or comments:	***Call if clinical concern***
RMO/Registrar name (print):	
RMO/Registrar signature:	
Consultant name (print):	
Consultant signature:	

Additional observations															
Date															
Time															
Pain score															
Probe change															
IV Site check															
Other (specify): _____															
Other (specify): _____															
Initial															

Urinalysis	Date/ Time	Specific Gravity	pH	Leuko-cytes	Blood	Nitrite	Ketones	Bilirubin	Uro-bilino-gen	Protein	Glucose	Initial

GENERAL OBSERVATION CHART PAEDIATRIC 1 - 4 YEARS 60192

General instructions for using chart

- Vital sign value must be recorded as a dot in the correct row as identified by its range.
- Observations must be represented graphically.
- For a vital sign in the extreme of a range (example $SpO_2 \leq 84$), also write the value.
- If vital sign falls in coloured area refer to PEWS legend to determine score.
- Add all scores to calculate **Total PEWS**.
- For PEWS ≥ 4 refer to PEWS Escalation Table.

Action if PEWS ≥ 4 or clinical condition deteriorating			
Date/ Time	**Reason for action** *(example PEWS 6)*	**Action taken** *(example: MO called to review patient)*	**Signature**

Pain Score –FLACC Pain Scale (behavioural)			
	SCORE 0	SCORE 1	SCORE 2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
ACTIVITY	Lying quietly normal position-moves easily	Squirming, shifting back/forth/ tense	Arched rigid or jerking
CRY	No cry (awake or asleep)	Moans or whimpers Occasional complaints	Crying steadily Screams or sobs Frequent complaints
CONSOLABILITY	Content, Relaxed	Reassured by occasional touching, hugging or talking to, distractable	Difficult to console or comfort

This score chart is used for the non-verbal child – adding the scores of each of the five points together from 1 – 10

Merkel, Voepel-Lewis, Shayevitz, & Malviya (1997)

Faces Pain Scale – Revised

0 **2** **4** **6** **8** **10**

"These faces show how much something can hurt. The left most face (point to this) shows no pain. The faces show more and more pain up to this one (point to the face on the right) which shows very much pain. Point to the face that shows how much you hurt right now."

FPS-R International Association of the Study of Pain © 2001

* 6 0 1 9 2 *

DO NOT WRITE IN THIS BINDING MARGIN

60192(1117)

DO NOT WRITE IN THIS BINDING MARGIN

60192(1117)

1 - 4 Years Age: _____	DATE																DATE
	TIME																TIME
Respiratory Rate (breaths/minute) ***Urgent review if RR is <_____ or >_____***	Write ≥ 50																Write ≥ 50
	45-49																45-49
	40-44																40-44
	35-39																35-39
	30-34																30-34
	25-29																25-29
	20-24																20-24
	15-19																15-19
	10-14																10-14
	Write ≤ 9																Write ≤ 9
Respiratory Rate Score																	
Effort of Breathing	Normal																Normal
	Mild																Mild
	Moderate																Moderate
	Severe																Severe
Effort of Breathing Score																	
			RA Room Air			**HFNP** High Flow Nasal Prongs				**NP** Nasal Prongs			**HM** Hudson Mask				
• Room Air • Nasal Prongs • Hudson Mask 4L																	• Room Air • Nasal Prongs • Hudson Mask 4L
• HFNP ≤ 1.5L/kg or • HFNP with FiO2 ≤ 40% or • HM > 4L																	• HFNP ≤ 1.5L/ kg or • HFNP with FiO2 ≤ 40% or • HM > 4L
• HFNP ≥1.6L/kg or • HFNP with FiO2 >40%																	• HFNP ≥1.6L/kg or • HFNP with FiO2 >40%
Oxygen Delivery Score																	
Oxygen Saturation (%) ***Urgent review if SpO_2 <_____***	98-100																98-100
	95-97																95-97
	93-94																93-94
	90-92																90-92
	87-89																87-89
	85-86																85-86
	Write ≤ 84																Write ≤ 84
Oxygen Saturation Score																	
Heart Rate (beats/minute) ***Urgent review if HR <_____ or >_____***	Write ≥180																Write ≥180
	170-179																170-179
	160-169																160-169
	150-159																150-159
	140-149																140-149
	130-139																130-139
	120-129																120-129
	110-119																110-119
	100-109																100-109
	90-99																90-99
	80-89																80-89
	70-79																70-79
	60-69																60-69
	50-59																50-59
	40-49																40-49
	Write ≤ 39																Write ≤ 39
Heart Rate Score																	
Blood Pressure (mmHg) v | ^ ***Urgent review if Systolic BP <_____ or > _____***	Write ≥ 145																Write ≥ 145
	140-144																140-144
	135-139																135-139
	130-134																130-134
	120-129																120-129
	110-119																110-119
	100-109																100-109
	90-99																90-99
	80-89																80-89
	75-79																75-79
	70-74																70-74
	Write ≤ 69																Write ≤ 69
Systolic Blood Pressure Score																	
Temperature (°C)	Write ≥ 39.6																Write ≥ 39.6
	39.1 - 39.5																39.1 - 39.5
	38.6 - 39.0																38.6 - 39.0
	38.0 - 38.5																38.0 - 38.5
	37.0 - 37.9																37.0 - 37.9
	36.1 - 36.9																36.1 - 36.9
	35.6 - 36.0																35.6 - 36.0
	35.0 - 35.5																35.0 - 35.5
	Write ≤ 34.9																Write ≤ 34.9
Temperature Score																	
Level of Consciousness (AVPU)	Alert																Alert
	Voice																Voice
	Pain																Pain
	Unresponsive																Unresponsive
AVPU Score																	
TOTAL PEWS																	**TOTAL PEWS**
Central Capillary Return	<3 sec																<3 sec
	≥3 sec																≥3 sec
	Initials																Initials

☐ Alteration to Calling Criteria
Refer to urgent review parameters documented in left column next to vital signs

Paediatric Early Warning Scores (PEWS)

0	1	2	3	4/MET

Effort of Breathing

(Advanced Paediatric Life Support Criteria for Effort of Breathing)

Stridor, accessory muscle use, recession, wheeze, nasal flaring, grunting, gasping

Normal	= nil of the above criteria
Mild	= 1 of the above criteria
Moderate	= 2 of the above criteria
Severe	= 3 or more of above criteria

PEWS Escalation Table			
PEWS	Notify	Escalate	Intra hospital escort
PEWS 4-5	Team Leader. RMO review within 30 minutes	After 60 minutes if no review and/ or no improvement escalate per PEWS 6-7	RN
PEWS 6-7	Team Leader. Registrar review within 30 minutes	After 60 minutes if no review and/ or no improvement escalate per PEWS ≥ 8	RN and RMO
PEWS ≥ 8	Team Leader. Registrar review immediately. Contact Consultant	Consider MET if no review and/or no improvement	RN and Registrar
Alteration to calling criteria ➔ Patient meeting urgent review criteria ➔ Registrar review within 15 minutes		Consider MET if no review and/or no improvement	RN and Registrar

Vital sign frequency and actions for PEWS ≥4:

- ➔ ½ hourly for 1 hour
- ➔ Commence fluid balance chart
- ➔ **If PEWS ≥ 6 BP must be measured with each set of vital signs**

If patient improves decrease frequency of vital signs to:

- ➔ Hourly for 4 hours
- ➔ 4 hourly for 24 hours

Guide for assessing Level of Consciousness using AVPU tool

Alert	Awake and alert OR asleep with no clinical indication to wake for assessment
Voice	Responds to verbal stimuli
Pain	Responds to painful stimuli
Unresponsive	No response to stimuli

Clinical indications for waking child up for assessment of level of consciousness include: neurological condition; post operatively or post procedure; medical orders; signs of clinical deterioration and/or PEWS ≥ 4.

Refer to Vital Sign Procedure for clarification.

MET Criteria (Dial "8" for MET)

Neonatal MET if < 10 months or < 10 kg

- Any observation in 4/MET zone
- SpO2 < 90 % on any O_2
- SpO2 < 60 % in patients with Cyanotic Heart Disease on any O_2
- Airway threat
- Respiratory or cardiac arrest

Paediatric MET if > 10 months or > 10 kg

- Sudden drop in level of consciousness
- Repeated or prolonged seizures
- Severe or worsening respiratory distress, exhaustion, apnoea or cyanosis
- Any patient you are worried about that does not fit this criteria

trim when printed on A3 paper