Paediatric Acute Recognition and Response Observation Tool

Age 1-4 years

St John of God Murdoch Hospital

Ward / Area: _____

U.R. Number .....

Surname .....

Given Names .....

Date of Birth ...../...../..... Sex .....

Use Label If Available or BLOCK LETTERS

Other charts in use

☐ Fluid Balance ☐ Weight ☐ Neurological ☐ Neurovascular ☐ Glucose monitoring ☐ Pain and analgesia ☐ Respiratory assessment ☐ Other

General instructions

General instructions for using chart

- To obtain an Early Warning Score all observations must be recorded
- Record the observation as a dot; connect to previous dot with a straight line to represent a graph
- Any observation outside graph area or in a coloured area must be written as a number in allocated box
- Always refer to local process

A full set of observations must be completed

- At time of initial presentation/admission to area and as appropriate for the patient's clinical condition
- When a patient is experiencing, or at risk of experiencing, an episode of acute deterioration
- When the clinician or family are worried about the patient

If observation falls within coloured area

- A full set of observations must be completed
- Refer to EWS Escalation or Sepsis Recognition Escalation Pathway for action plan, unless a modification has been made: refer to local process

Modification to Early Warning Score (EWS)

- Acceptable parameters can be modified based on the patient's specific clinical, treatment and/or pre-existing conditions.
- All modifications must adhere to local process and be reviewed frequently by the treating consultant.
- **Modifications must NEVER be used to normalise a clinically unstable patient.**

Observations	Accepted parameters and modified EWS	Date and time	Duration (hrs)	Name and signature
		/ / :		Name
Reason:				Signature
		/ / :		Name
Reason:				Signature
		/ / :		Name
Reason:				Signature

Events – record event details, including interventions, and concerns from clinician or family

	Intervention/comment	Initials
A		
B		
C		
D		
E		
F		
G		
H		
I		
J		

Supported by WAHTN

METROPOLITAN

Age 1-4 years

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HR 480P-C

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Involve the family

- Include the parent/carer in determining what is normal for their child and what may have changed
- Acknowledge parental concern – they know their child best
- Engage with the parent/carer to agree a management plan and escalation criteria
- If applicable assess observations with parent/carer to review parental concern

Patients of concern include those with

- Increasing oxygen requirement
- Changes in circulation (e.g.mottled/pallor)
- Altered mental state
- Greater than expected fluid loss
- Reduced urine output (<1mL/kg/hr)
- New, increasing or uncontrolled pain
- Blood glucose level ≤3mmol/L
- Family or clinician worried
- Changes to respiratory distress

Assessment of respiratory distress

Instructions – Select the score related to the highest criteria obtained for the patient's clinical condition

	MILD – Score 1	MODERATE – Score 2	SEVERE – Score 3
Airway	• Stridor on exertion/crying	• Some inspiratory stridor at rest • Partial airway obstruction	• Biphasic stridor at rest • Imminent airway obstruction
Behaviour and feeding	• Normal • Age appropriate vocalisation	• Some/intermittent irritability • Difficulty talking/crying • Difficulty feeding or eating	• Increased irritability or lethargy • Looks exhausted • Unable to talk or eat • Changes in conscious state such as agitated, confused or drowsy
Respiratory rate/pattern	• Mildly increased	• Respiratory rate increased • Abnormal pauses	• Respiratory rate significantly increased/absent breath sounds/silent chest • Increased/reduced respiratory rate as child tires
Work of breathing	• Mild intercostal and suprasternal recession	• Moderate intercostal and suprasternal recession • Nasal flaring or tracheal tug	• Marked intercostal, suprasternal and sternal recession
Other		• May have brief apnoeas (5-10 secs)	• Gasping, grunting • Extreme pallor, cyanosis • Increasingly frequent or prolonged apnoeas (≥20 secs)

Level of consciousness AVPU

ALERT Awake and alert | **VOICE** Responds to verbal stimuli | **PAIN** Responds to painful stimuli | **UNRESPONSIVE** No response to stimuli

Level of Sedation (UMSS – University of Michigan Sedation Scale) ONLY complete if sedation administered as per local policy	**Response**
0 = Awake and alert	Monitor
1 = Minimally sedated: may appear tired/sleepy, responds to verbal conversation and/or sound	Monitor
2 = Moderately sedated: somnolent/sleeping, easily roused with tactile stimulation or simple verbal command	Monitor
3 = Deep sedation: deep sleep, rousable only with deep or physical stimulation	Review by Paediatric Anaesthetist
4 = Unrousable	Medical Emergency Call

Pain scales used – select (with tick) appropriate pain assessment tool

☐ **FLACC**

Each category is scored 0-2, resulting in a total score of 0-10. Add the score of each box and total to a score of 10.

☐ **FPS-R**

The face on the left means no pain and on the far right means extreme pain, ask the patient to point to the face that shows how much you hurt right now.

Categories	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 and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadlily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Communicate on the importance of timely action in recognising and responding to a patient's changing condition

NEEDS

- What type of review does this patient need?
- What is the time frame for this review?
- What do I need to do or say right now to ensure my patient is safe?

OBSERVATIONS

- What are the specific observations raising concerns about the patient?
- What do I know about my patient's condition?
- What clinical signs and symptoms are a problem?

WHY

- What are the potential consequences to the patient if there is a delay in taking action?

NOW iSOBAR

Establish the level of need and urgency, then plan the required communication

NO WRITING IN MARGINS

U.R. Number .....

Surname .....

Given Names .....

Date of Birth ...../...../..... Sex .....

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Date																											
Time																											
Family/clinician concern*	1																									1	
	0																									0	

AIRWAY & BREATHING

Any airway threat escalate to MEDICAL EMERGENCY. If any increase in oxygen requirement, consider early escalation.

Assessment of respiratory distress See back of chart*	Severe	3																								3	Severe
	Moderate	2																								2	Moderate
	Mild	1																								1	Mild
	Nil	0																								0	Nil
Respiratory rate breaths/minute Assess for 60 seconds	≥60	3																								3	≥60
	55	3																								3	55
	50	2																								2	50
	45	1																								1	45
	40	1																								1	40
	35	0																								0	35
	30	0																								0	30
	25	0																								0	25
	20	0																								0	20
	15	2																								2	15
	≤10	3																								3	≤10
		ME																								ME	
Respiratory rate (number)																											
O_2 saturations	≥92	0																								0	≥92
	89-91	1																								1	89-91
	86-88	2																								2	86-88
	≤85	ME																								ME	≤85
O_2 saturations % (number %)																											
Probe change																											Probe Δ

O_2 therapy instructions For HHF only use FiO_2 Room air **(RA)** Nasal prongs **(NP)** Face mask **(FM)** Non-rebreather mask **(NRM)** Tracheostomy **(T)** CPAP **(C)** Non-Invasive ventilation **(NIV)** HHFNP **(HHF)**

O_2 therapy litres/minute or FiO_2	≥10L	>50%	3																							3	
	>5-10L	40-49%	2																							2	
	>2-5L	30-39%	1																							1	
	≤2L	21-29%	0																							0	
Mode of O_2 delivery																											

CIRCULATION

If the temperature, HR and CRT is increased, refer to Sepsis Recognition Escalation Pathway

Heart rate beats/minute Assess for 60 seconds	≥180	3																								3	≥180
	170	3																								3	170
	160	2																								2	160
	150	1																								1	150
	140	1																								1	140
	130	0																								0	130
	120	0																								0	120
	110	0																								0	110
	100	0																								0	100
	90	1																								1	90
	80	2																								2	80
	70	3																								3	70
	≤60	ME																								ME	≤60
Heart rate (number)																											
Blood pressure (mmHg) Score on systolic. Mark BP as. Mark X for MAP	≥130	3																								3	≥130
	125	1																								1	125
	120	1																								1	120
	115	0																								0	115
	110	0																								0	110
	105	0																								0	105
	100	0																								0	100
	95	0																								0	95
	90	0																								0	90
	85	0																								0	85
	80	1																								1	80
	75	1																								1	75
	70	2																								2	70
	65	2																								2	65
	60	3																								3	60
	55	3																								3	55
	<50	ME																								ME	<50
Blood pressure (mmHg)	Systolic/Diastolic																										
Capillary refill time Central (seconds)	≥4 seconds	2																								2	≥4 secs.
	2-3 seconds	1																								1	2-3 secs.
	<2 seconds	0																								0	<2 secs.

DISABILITY

If not alert, consider GCS assessment. Consider clinician review for unrelieved/unexpected pain. Pain scale used: ☐ FLACC ☐ FPS-R

Pain scale*	7-10	2																								2	7-10
	4-6	1																								1	4-6
	0-3	0																								0	0-3
Level of Consciousness* **AVPU**	Alert	0																								0	Alert
	Voice	1																								1	Voice
	Pain	2																								2	Pain
	Unresponsive	ME																								ME	Unresp.
Blood sugar level																											

EXPOSURE

If suspected infection or temperature <36°C or ≥38°C refer to Sepsis Recognition Escalation Pathway

Temperature °C	>40	–																									>40
	39.5	–																									39.5
	39	–																									39
	38.5	–																									38.5
	38	–																									38
	37.5	–																									37.5
	37	–																									37
	36.5	–																									36.5
	36	–																									36
	35.5	–																									35.5
	35	–																									35
Temperature °C (number)																											
Total Early Warning score																											
Events																											
Initials																											

Early Warning Score Escalation Pathway

Score	Clinical response
	• Remain vigilant • Complete a full set of observations • Notify nurse in charge • Optimise treatment • A plan must be documented • Reassess EWS after interventions • Consider transfer to higher care • Ensure Treating Team are aware of deterioration
1-3	**Senior Nursing Review** • Increase frequency of observations • Consider Medical Review
4–5	**Timely Medical Review** • Request Treating Team to review within 30 mins. • Reassess EWS within 30 mins. of review
6–7	**Urgent Review / MER** • Request VMO / Anaesthetist to review within 15 mins. • Senior nursing review • Reassess EWS within 15 mins. of review • If no response within 15 minutes, or if clinically concerned place a Medical Emergency Call
8+	**MER / Code Blue** • Request VMO / Anaesthetist review within 5 mins. • Senior nursing review • Assess the patient and initiate appropriate clinical care • If no response within 5 mins. or if clinically concerned place a Medical Emergency Call
ME	**Immediate Medical Emergency Call** • Initiate BLS and/or APLS as required

Emergency Call for any of the following:

- Airway threat
- Cardiac or respiratory arrest
- Apnoea or cyanosis
- Seizure/prolonged convulsion
- Major bleeding
- Severe respiratory distress
- Any observation in the purple zone
- You are worried about the patient

Sepsis Recognition Escalation Pathway

Use if suspected infection **OR** abnormal temperature (<36°C or ≥38°C)

Consider sepsis, bacterial infection and need for antibiotics. If sepsis recognition prompt not triggered, respond as per early warning score.
Action as per paediatric sepsis guideline.

High-risk patients – have a lower threshold for requesting medical review if:

- Infants less than 3 months
- Immunosuppression, chemotherapy, long-term steroids or asplenia
- Invasive devices
- Recent surgery, burn or wound
- Unimmunised/incomplete immunisation
- Rural, remote or low socioeconomic status
- Re-presentation or delayed presentation

Sepsis recognition prompt	Clinical Response
EWS 6-7 **OR** any of the following • Mottled, CRT ≥3 or cold peripheries • Non-blanching rash • Drowsy or confused • Unexplained pain • Lactate 2–4 mmol/L • Family and/or clinician concern is continuing or increasing	**Urgent Review / MER** • Request VMO / Anaesthetist review within 15 mins. • **State "sepsis review required"** • Senior nursing review • Refer to paediatric sepsis guideline • Reassess EWS within 15 mins. • Consider Critical Care referral/transfer of care
EWS 8+ **OR** any of the following • Any observation in red zone • AVPU score P • Lactate >4 mmol/L • BGL <3 mmol/L	**MER / Code Blue** • Request VMO / Anaesthetist review within 5 mins. • **State "sepsis review required"** • Senior nursing review • Refer to paediatric sepsis guideline • Assess the patient and initiate appropriate clinical care • If no response within 5 mins. or if clinically concerned place Medical Emergency Call

Level of sedation UMSS*

(ONLY complete if sedation administered)

Date													
Time													
0	0												
1	0												
2	0												
3	RR												
4	ME												