Government of Western Australia
Child and Adolescent Health Service

Perth Children's Hospital

# ESCALATION System Version 5 Education Resource

Updated

Paediatric Acute Recognition and Response Observation Tool (PARROT v5)

ESCALATION
RECOGNISING AND RESPONDING TO PAEDIATRIC CLINICAL DETERIORATION IN WA

Curtin University

For more NSQHS Standard resources please refer to the CAHS Information Hub
Prepared by: CAHS Nursing Education in conjunction with PCH Escalation v5 Working Group
Endorsed by: PCH/N Standard 8 Committee
Last Review: Feb 2025
Next Review Date: Feb 2027

Compassion | Excellence | Collaboration | Accountability | Equity | Respect

Healthy kids, healthy communities

Government of Western Australia
Child and Adolescent Health Service

Perth Children's Hospital

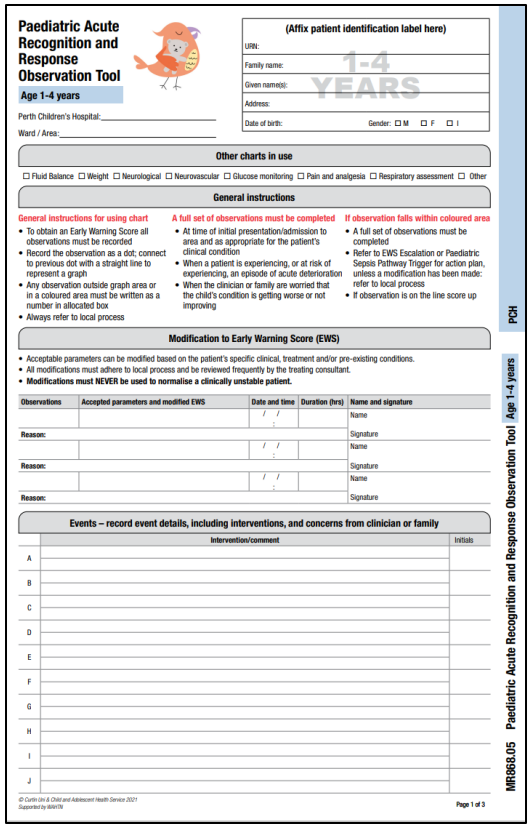
# ESCALATION System Version 5 Education Resource



*Child and Adolescent Health Service*
*CAHS Nursing Education*
*Perth Children's Hospital*
*Telephone: (08) 6456 0515*
*Produced by CAHS Nursing Education*

# Escalation System Version 5 (PARROT)

The following education resource has been created to highlight updates to the **Escalation PARROT v5** and Observation, Monitoring and Paediatric Acute Recognition and Response Observation Tool (PARROT) procedure.


Paediatric Acute Recognition and Response Observation Tool

Age 1-4 years

(Affix patient identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Gender: ☐ M ☐ F ☐ I

1-4 YEARS

Perth Children's Hospital:

Ward / Area:

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 that the child's condition is getting worse or not improving

If observation falls within coloured area
- A full set of observations must be completed
- Refer to EWS Escalation or Paediatric Sepsis Pathway Trigger for action plan, unless a modification has been made: refer to local process
- If observation is on the line score up

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 | | |

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PCH

Age 1-4 years

Paediatric Acute Recognition and Response Observation Tool

MR868.05

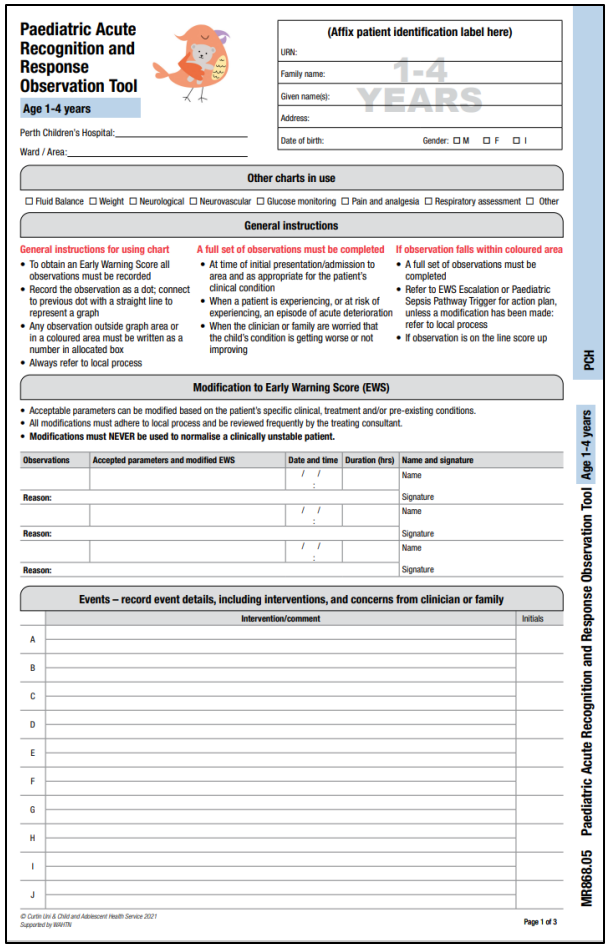
## Learning Outcomes:

- Discuss targeted specific questions when assessing family concern
- Discuss new variable in recognising and responding to acute deterioration
  - ➢ Changing Behaviour
  - ➢ New Confusion
- Recognise possible underlying pathophysiology, condition or cause for Changing Behaviour/ New Confusion
- Discuss key aspects of identifying changing behaviour and assessment
- Watch video and complete case study of Changing Behaviour in children < 12 months
- Discuss key aspects of identifying new confusion and assessment
- Watch video and complete case study New Confusion in children > 1 year of age
- Identify updates and discuss responsibility of Senior Nurse Review in recognising and responding to acute deterioration

# Escalation – PARROT v5

The following education resource has been created to highlight updates to the **Escalation PARROT v5** and Observation, Monitoring and Paediatric Acute Recognition and Response Observation Tool (PARROT) procedure.

Version 5 of the PARROT chart applies to all PCH inpatient areas, ED, HITH, PACU and outpatients use.


Paediatric Acute Recognition and Response Observation Tool

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1-4 YEARS

Perth Children's Hospital:

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

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PCH

Age 1-4 years

Paediatric Acute Recognition and Response Observation Tool

MR9868.05

## Key changes

Targeted specific questions when **assessing family concern** to increase clarity and consistency

Addition of ***NEW*** variable under Disability when assessing Level of Consciousness. New variable assessed in conjunction with (AVPU and UMSS)

- < 1year of age – Changing behaviour
- > 1 year of age – New confusion

- Changes to "Responding to Pain " in AVPU now scores **3**

Formatting updates

- Grey background to some of the headings and rounded corners
- Removal of asterisks
- Updated wording under General Instructions and Patients of concern

Additional instruction and wording changes

- Early Warning Score Escalation Pathway information & Senior Nursing Review
- Paediatric Sepsis Pathway Trigger information

# Assessing Family Concerns

Family or caregiver concern is highly predictive of paediatric patient deterioration, and is a **weighted variable** when undertaking patient assessment with the PARROT chart.

**Involve the family**

- **ASK** – How do you think your child is doing?
- **ASK** – Has anything changed?
- **ASK** – Are you worried your child is getting worse?

**Targeted and specific questions**

To support staff when assessing family concern (Family/ Clinician concern variable) the below questions have been revised in PARROT v5

Involve the family by asking

- "How do you feel your child is doing?"
- "Has anything changed?"
- "Are you worried your child is getting worse?"

Remember it is important to:

- Acknowledge and validate their concerns, even if observations appear stable
- Provide clear information about what you are observing
- Always document concerns/changes and escalate according to Escalation Pathway

# Assessing Family Concerns

The following video demonstrates the NEW targeted questions to support the clinician with identifying family concern.

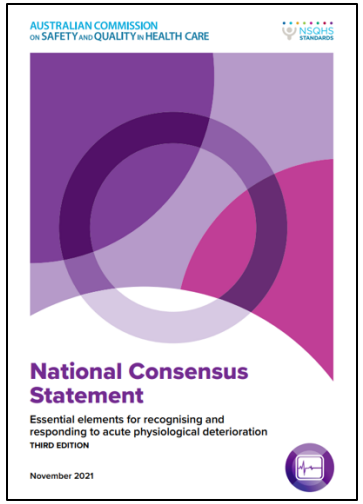
# New Variable: "Changing behaviour" and "New confusion"

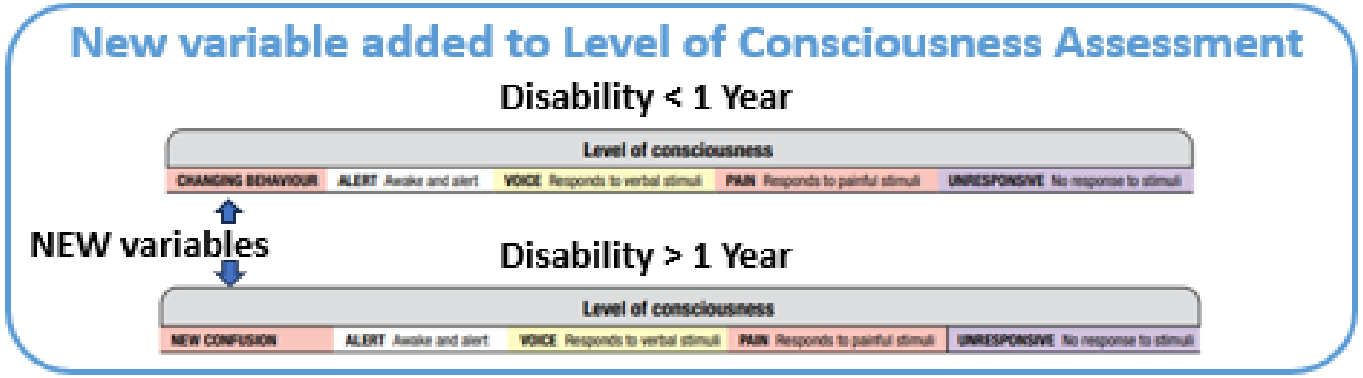
Recognising and responding to acute deterioration is governed by the Australian Commission on Safety and Quality in Health Care – *clinical care standards on recognising and responding to acute physiological deterioration*.

This standard recommends, monitoring and observation plans should include:

- Respiratory Rate
- Oxygen Saturation
- Heart Rate
- Blood Pressure
- Temperature
- Level of Consciousness; AVPU and/or UMSS

➢ ***NEW VARIBLE * New Confusion or Changing Behaviour**



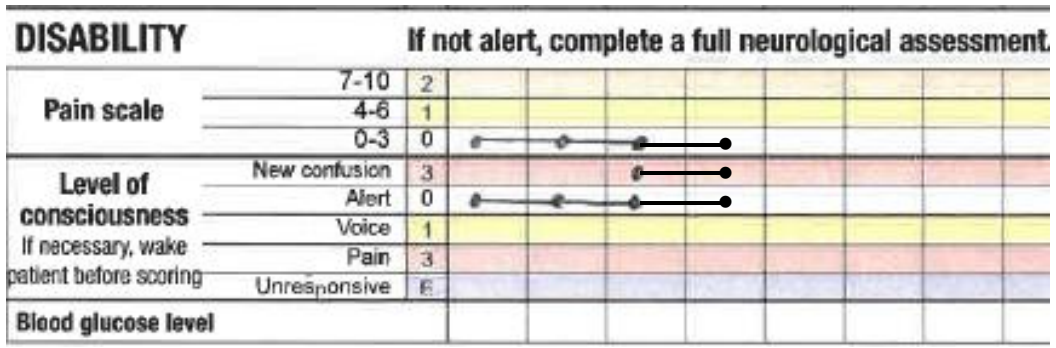



# Changing behaviour and New confusion

The addition of **New Confusion** or **Changing Behaviour** has been added under **Level of Consciousness and must be assessed in addition to the assessment of AVPU** on the Paediatric Acute Recognition and Response Observation Tool (PARROT). The new variables are **age-dependent**, and ages and stages of development need to be considered.

When scoring under both **New Confusion or Changing Behaviour** and AVPU the scores are cumulative.

Both variables need to be graphically represented as connected dots.




## Assessing Changing behaviour / New Confusion on the PARROT Chart

| | | |
|---|---|---|
| Changing behaviour (assessed in children < 1 year) | 3 | **Changing behaviour.** Refers to a noticeable deviation from an infant's typical patterns of action, expression, or response.<br>Examples of Changing behaviour in an infant may include (but not limited to):[16,17]<br>• Not making eye contact with caregiver<br>• Underactive or hyperactive when awake<br>• Less than usual words / vocal sounds<br>• Inconsolable / irritable cry<br>• Restless |
| New confusion (assessed in children > 1 year) | 3 | **New confusion.** Refers to new onset disorientation, or cognitive impairment, where previously their mental state was normal for their developmental age – this may be subtle. The patient may respond to questions coherently, but there is some confusion, disorientation and/or agitation.<br>Examples of New confusion may include (but not limited to):[16,17,18.]<br>• Disorientation<br>• Reduced awareness<br>• Disorganised thinking<br>• Non purposeful actions (e.g. repetitive movements)<br>• Impaired speech<br>• Agitated, inconsolable, or restless |

## Assessing AVPU on the PARROT chart

| | | |
|---|---|---|
| **A** | **0** | **Alert.** The patient is alert and interactive.<br>If the patient is acutely confused, a Glasgow Coma Score must be obtained, and the Clinical Emergency Response System should be activated. |
| **V** | **1** | **Voice.** The patient responds to voice.<br>If the patient is abnormally drowsy assess the patients Glasgow Coma Score (GCS). If this is a sudden change in conscious state activate a MET Review or CODE BLUE |
| **P** | **3** | **Pain.** The patient responds only to central pain.<br>If the patient responds only to pain, assess the patients Glasgow Coma Score (GCS) and reassess regularly. If this is a sudden change in neurological status, then activate a MET Review or CODE BLUE immediately. |
| **U** | **E** | **Unresponsive.** The patient is unresponsive.<br>A CODE BLUE must be activated.<br>A Glasgow Coma Score must be obtained. |

# Causes for Changing Behaviour/ New Confusion

***Changing behaviour*** (assessed in < 12 months old) or ***New confusion*** (assessed in > 1 year old) can be an indicator of a significant change resulting in acute clinical deterioration which may require early escalation.

There are many underlying conditions and causes. The most vital role is to assess, **identify early, and escalate** for further management.

| Possible underlying pathophysiology, condition or cause | |
|---|---|
| Infection – e.g., sepsis, meningitis | Electrolyte imbalances - e.g., hyponatremia, hypercalcemia |
| Hypotension (low blood pressure) | Hypoxia (low oxygen levels) |
| Hypercapnia (elevated carbon dioxide levels) | |
| Side effects of medication – e.g., sedatives, anticholinergics, or opioids | |
| Hypoglycaemia or hyperglycaemia (low or elevated glucose levels) | |
| Neurological conditions – e.g., stroke, traumatic brain injury, seizure | |
| Withdrawal syndromes – e.g., drug or alcohol withdrawal | |
| Delirium: for further information about delirium refer to the CAHS Policy on Recognising and Responding to Acute Deterioration and the PCH PCC policy on Delirium Assessment and Management | |

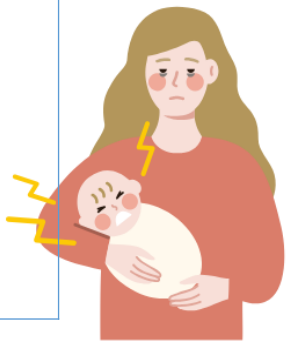
# Identifying Changing Behaviour in children < 12 months

Changing behaviour will be assessed on both the 3 month and < 1 year PARROT charts

**Changing Behaviour**, in infants < 12 months of age, refers to a noticeable deviation from an infant's typical patterns of action, expression, or response. Identification of new confusion in this age group is difficult to distinguish and is a sign of potentially serious clinical deterioration.

When assessing for **changing behaviour**, it is important to discuss with parents/caregivers, as they know their child best and can recognise changes that may indicate early signs of deterioration.

| Questions to aid assessment<br>Cornell Assessment of Paediatric Delirium Tool (CAPD) | Examples of Development Anchors in an Infant < 1year of age |
|---|---|
| 1. Does the child make eye contact with the caregiver? | Refer to Appendix 3: **Developmental Anchors** Delirium Assessment and Management for a description of typical behavior for the newborn, 4 weeks, 6 weeks, 8 weeks, 28 weeks, and the 1-year-old.<br><br>Examples of Changing Behaviour in an infant may include (but not limited to):<br>• Not making eye contact with a caregiver<br>• Underactive<br>• Hyperactive when awake e.g. cycling legs or arms<br>• Inconsolable despite comfort and pain relief<br>• Restless/ Jittery<br>• Reflex present/ absent or abnormal<br>• Disruptive sleep pattern |
| 2. Are the child's actions purposeful? | |
| 3. Is the child aware of his/her surroundings? | |
| 4. Does the child communicate needs and wants? | |
| 5. Is the child restless? | |
| 6. Is the child inconsolable? | |
| 7. Is the child underactive – very little movement whilst awake? | |
| 8. Does it take the child a long time to respond to interactions? | |

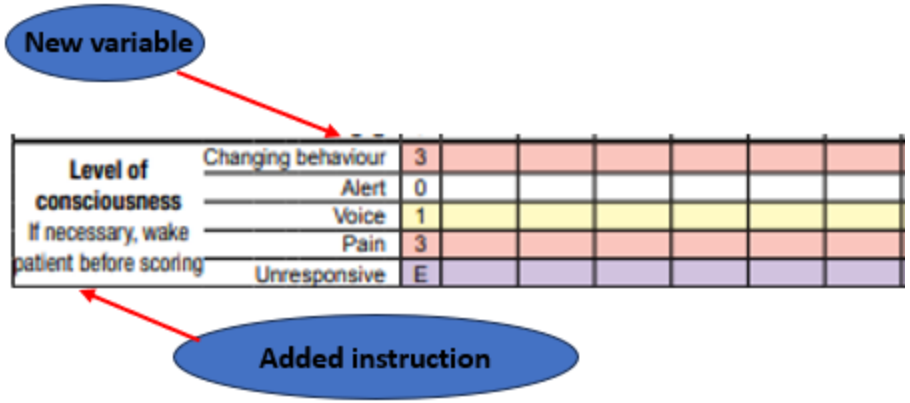


# Assessment of Changing Behaviour in children < 1year of age

This video demonstrates the assessment and documentation using Changing Behaviour in infant < 12 months of age used by the clinician.

# Assessment of
## Changing Behaviour in infants < 12 months of age

- When assessing for ***Changing behaviour***, consider the developmental norms appropriate for the infant's age, alongside what is typical for that individual infant.
- Remember to include the family in any assessment. They know their child the best and can recognise early signs of change.
- *If* ***Changing behaviour*** (assessed in infants < 12 months of age) is identified = score 3 on the PARROT
- Ensure to escalate via the Escalation Pathway. Remember to document observations and escalation contemporaneously, and communicate the changes to the shift coordinator.




# Case Study Changing Behaviour in Infant <12 Months

## Time to Practice

**Patient Details**

Name: Mia, 6 months old

Reason for Admission: Failure to Thrive, poor feeding, trending weight loss. Mia is needing to be woken for feeds and is feeding poorly.

**Scenario**

During your morning assessment, Mia's mother reports:

- Mia is "different today."
- She is underactive and not making eye contact with her mother and doesn't engage with her usual toys.
- She's less interested in feeding compared to her usual pattern.

**Observations**

Respiratory rate: 55 breaths per minute

Heart rate: 140 beats per minute

Blood Pressure: 95/70

Temperature: 38.2°C

Central refill time: 2 seconds.

AVPU: Alert

Noticed to be '*not her usual self*'

**Actions**

1. Assess Mia's vitals, behaviour and score using the PARROT V5 chart.
2. What would you ask Mia's Mother?
3. Document your findings, including family concerns, and score "changing behaviour."
4. Determine whether escalation is needed and describe your next steps.

# Identifying New Confusion in children > 1 year of age.

New confusion, is assessed in children > 1 year of age and refers to **new onset** disorientation, or cognitive impairment, where previously their mental state was normal for their developmental age – this may be subtle.

The patient may respond to questions coherently, but there is some confusion, disorientation and/or agitation.

Remember, when assessing for **new confusion**, it is essential to ask the family what is normal for their child as they know their child the best and can recognise changes that may indicate early signs of deterioration.

| Questions to aid identification of New confusion (CAPD) | Examples of New confusion in Children may include (but not limited to): |
|---|---|
| 1. Does the child make eye contact with the caregiver? | • Disorientation – e.g., to time, place, surroundings and/or caregiver<br>• Reduced awareness – e.g., no eye contact ,reduced focus on objects, doesn't remember what was said<br>• Reduced or disruptive sleep patterns<br>• Disorganised thinking - e.g., confused words<br>• Non-purposeful actions e.g. repetitive movements, cycling movements<br>• Impaired speech – e.g., inappropriate words or incomprehensible sounds<br>• Agitated, inconsolable, or restless –not consoled by usual methods e.g., singing, holding, talking, reading or parental comfort actions/ soothing. |
| 2. Are the child's actions purposeful? | |
| 3. Is the child aware of his/her surroundings? | |
| 4. Does the child communicate needs and wants? | |
| 5. Is the child restless? | |
| 6. Is the child inconsolable? | |
| 7. Is the child underactive – very little movement whilst awake? | |
| 8. Does it take the child a long time to respond to interactions? | |

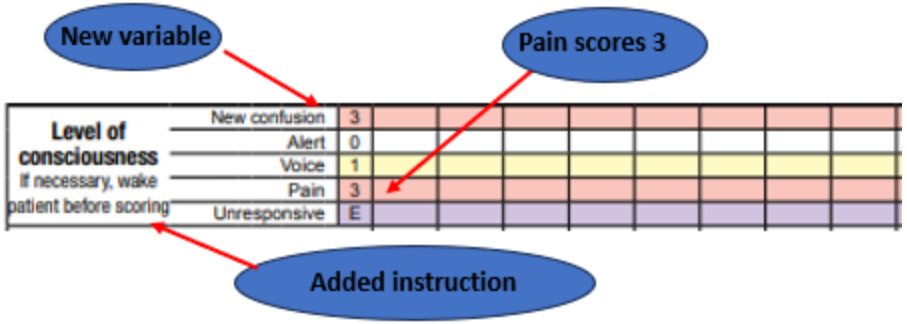
Neurological Observations (health.wa.gov.au) and Delirium Assessment and Management

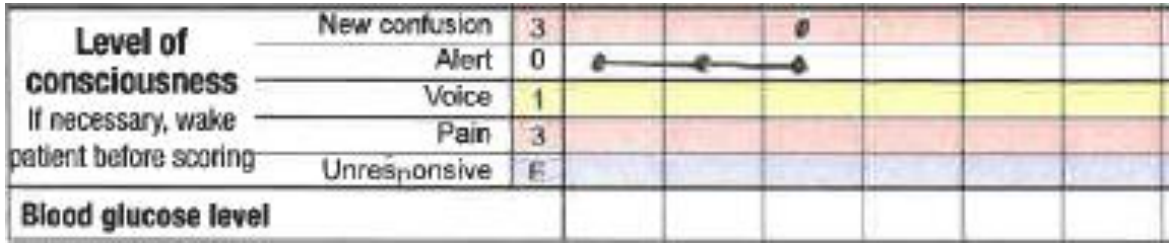
# Assessment of New Confusion > 1 year of age

This video demonstrates of the assessment and documentation using New confusion in children > 1 year of age used by the clinician.


# Assessment of
## New confusion in children > 1 year of age

- When assessing for ***New confusion***, consider the developmental norms appropriate for the child's age, alongside what is typical for that individual child.
- Remember to include the family in any assessment of clinical deterioration. They know their child the best and can recognise early signs of deterioration.
- ***New confusion*** (assessed in children > 1 year of age) is identified = score 3 on the PARROT.
- Ensure to escalate via the escalation pathway. Remember to document observations and escalation contemporaneously, and communicate the changes to the shift coordinator.



# Case Study 2: Adolescent

## Time to Practice

**Patient Details**

Name: Mohammed, 14 years old

Reason for Admission: Post-operative recovery following an appendicectomy, you were informed the appendix had perforated prior surgery and he is on intravenous antibiotics, intravenous hydration, simple and opioid analgesia for pain.

**Scenario**

During your afternoon rounds, you notice:

- Mohammed is slower to respond to questions and seems disoriented.
- He incorrectly identifies his location as his home instead of the hospital.
- He has difficulty focusing on conversations and appears drowsy despite being awake.
- His parents report that he was "fine" this morning.

**Observations**

Respiratory rate: 18 breaths per minute

Heart rate: 95 beats per minute

Blood Pressure: 95/70

Temperature: 35.9°C

Capillary refill time: 3 seconds.

AVPU: Responds to voice

Noticed to be: Confused

**Actions**

1. Assess Mohammed's vital signs and AVPU and document it is using the PARROT V5 chart.
2. What would you ask Mohammed's parents?
3. Identify whether Mohammed meets the criteria for "new confusion" and score accordingly.
4. Escalate care by outlining the steps you would take?

# Updated Escalation Pathway & Senior Nursing Review

[Observation, Monitoring and Paediatric Acute Recognition and Response Observation Tool (PARROT) procedure]

**Early Warning Score Escalation Pathway**

- Remain vigilant
- Complete a full set of observations
- Notify nurse in charge
- Optimise treatment
- A plan must be documented
- Reassess EWS after interventions
- Ensure Treating Team are aware of deterioration

| Score | Clinical response |
|---|---|
| 1-3 | **Senior Nursing Review**<br>• Increase frequency of observations<br>• Consider Medical Review |
| 4–5 | **Timely Medical Review**<br>• Request Treating Medical Team or STARS RMO to review within 30 mins<br>• Reassess EWS within 30 mins of review<br>• Request STARS CNS review |
| 6–7 | **Urgent Treating Team Review**<br>• Request Treating Medical Team or STARS Registrar to review within 15mins<br>• Reviewing doctor to notify Consultant (or Senior Registrar in ED overnight)<br>• Consider PCC referral<br>• Reassess EWS within 15 mins of review |
| 8+ | **Rapid Response Review**<br>• ED: Request Consultant (or Registrar overnight) to review within 5 mins. Consider PCC referral<br>• Ward: Request MET review within 5 mins.<br>• MET to notify treating Consultant<br>• Assess the patient and initiate appropriate clinical care<br>• If no response within 5 mins or if clinically concerned place Code Blue Call |
| E | **Immediate Code Blue Call**<br>• 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
- You are worried about the patient

**Senior Nursing Review Initiated for EWS 1-3**

**The senior nursing review should include the following ABCDE assessment**

| AIRWAY | BREATHING | CIRCULATION | DISABILITY | EXPOSURE |
|---|---|---|---|---|
| • Assess patency- consider obstruction/ compromise<br>• Listen for airway noises, presence of cough<br>• Assess artificial airways if present (NPA/ tracheostomy)<br>• Consider nasal +/- oral suction | • Resp rate<br>• SpO2<br>• Auscultate<br>• Assess for resp distress as per back of PARROT chart<br>• Check NIV/ ventilation circuit if using | • Heart rate<br>• ECG rhythm if monitored<br>• Pulse strength<br>• Blood pressure<br>• Central cap refill<br>• Colour of skin and mucous membranes<br>• Skin temperature and turgor<br>• Urine output/ fluid balance | • Changing behaviour <1yr, New confusion >1yr and APVU<br>• FNO<br>• Pain<br>• Sedation score<br>• Fontanelles<br>• Seizure activity<br>• BGL | • Temperature<br>• Rashes<br>• Skin integrity<br>• Abdominal swelling<br>• Inspect all invasive devices |

*Problems should be addressed as they are identified, with the patient reassessed after each intervention.*

*If the patient continues to deteriorate – **Escalate, don't hesitate***

**Documentation**

A Senior Nursing Review can be conducted by a registered nurse, in roles such as

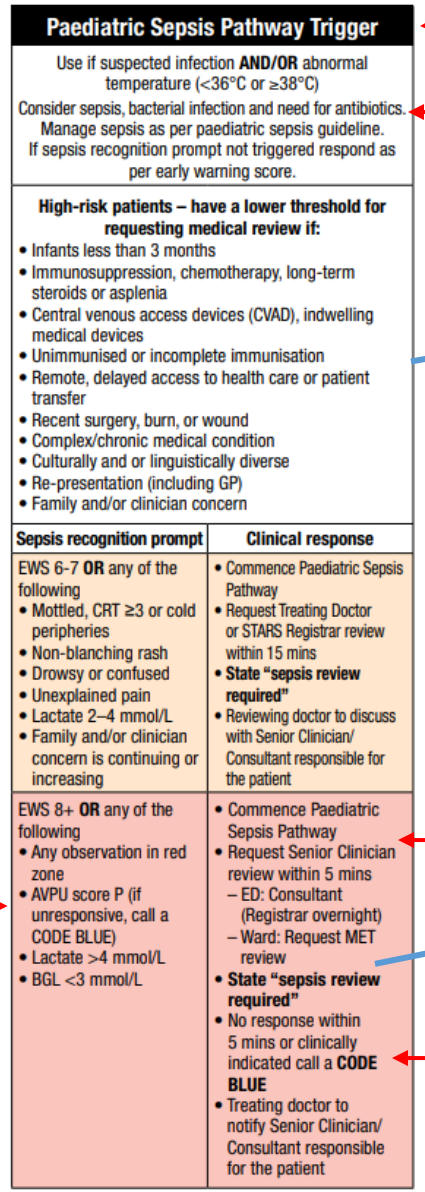
- Shift Coordinator
- Clinical Nurse Manager
- Liaison Nurse
- Staff Development Nurse
- Senior Registered Nurse
- Clinical Nurse

This nurse will apply their clinical judgement after they are asked to review a patient

This assessment may include any or all elements of the 'Decision making flowchart for a Senior Nursing Review'

**Documentation** of the assessment and escalation is an essential aspect of the senior nursing review

# Sepsis Pathway Trigger - has been renamed to align with Paediatric Sepsis Pathway



**Paediatric Sepsis Pathway Trigger**

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

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

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

- Infants less than 3 months
- Immunosuppression, chemotherapy, long-term steroids or asplenia
- Central venous access devices (CVAD), indwelling medical devices
- Unimmunised or incomplete immunisation
- Remote, delayed access to health care or patient transfer
- Recent surgery, burn, or wound
- Complex/chronic medical condition
- Culturally and or linguistically diverse
- Re-presentation (including GP)
- Family and/or clinician concern

| Sepsis recognition prompt | Clinical response |
|---|---|
| EWS 6-7 **OR** any of the following<br>• Mottled, CRT ≥3 or cold peripheries<br>• Non-blanching rash<br>• Drowsy or confused<br>• Unexplained pain<br>• Lactate 2–4 mmol/L<br>• Family and/or clinician concern is continuing or increasing | • Commence Paediatric Sepsis Pathway<br>• Request Treating Doctor or STARS Registrar review within 15 mins<br>• **State "sepsis review required"**<br>• Reviewing doctor to discuss with Senior Clinician/ Consultant responsible for the patient |
| EWS 8+ **OR** any of the following<br>• Any observation in red zone<br>• AVPU score P (if unresponsive, call a CODE BLUE)<br>• Lactate >4 mmol/L<br>• BGL <3 mmol/L | • Commence Paediatric Sepsis Pathway<br>• Request Senior Clinician review within 5 mins<br>– ED: Consultant (Registrar overnight)<br>– Ward: Request MET review<br>• **State "sepsis review required"**<br>• No response within 5 mins or clinically indicated call a **CODE BLUE**<br>• Treating doctor to notify Senior Clinician/ Consultant responsible for the patient |

New name

Wording change

Added direction

Wording changes

Added direction to notify medical staff

**Additional High-Risk Patients to include:**

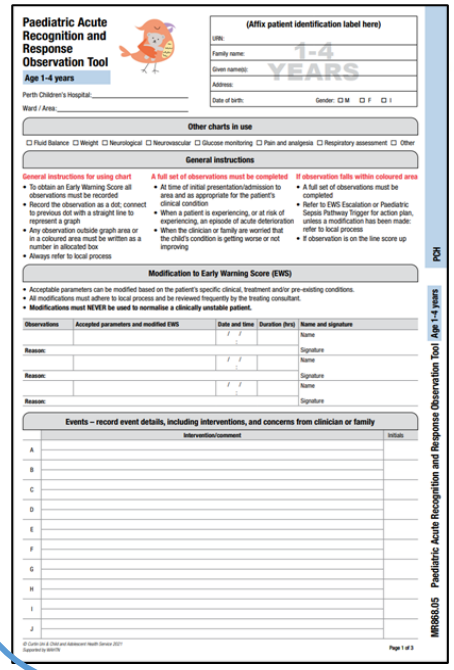
- Central venous access devices (CVAD), indwelling medical devices.
- Unimmunised or incomplete immunisation
- Remote, delayed access to healthcare or patient transfer
- Culturally or linguistically diverse
- Family and/or clinician concern

**EWS 8+ New Directions**

- AVPU score P (if unresponsive, call a **CODE BLUE**)
- Treating doctor to notify Senior Clinician /Consultant responsible for the patient

# Key Chart & Assessment Changes to Version 5

## General Updates and Design Changes


Paediatric Acute Recognition and Response Observation Tool

Age 1-4 years

(Affix patient identification label here)

1-4 YEARS

Other charts in use

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 that the child's condition is getting worse or not improving

If observation falls within coloured area
- A full set of observations must be completed
- Refer to EWS Escalation or Paediatric Sepsis Pathway Trigger for action plan, unless a modification has been made: refer to local process
- If observation is on the line score up

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 | | |

PCH

Age 1-4 years

Paediatric Acute Recognition and Response Observation Tool

MR868.05

Page 1 of 3

**General instructions**

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- If observation is on the line score up

More comprehensive instruction

Additional Instruction

Change in title of "Paediatric Sepsis Pathway Trigger"

If observation falls on the line score up

Removal of asterisks

| | | |
|---|---|---|
| Date | | |
| Time | | |
| Family/clinician concern | | 1 / 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 |
| | Moderate | 2 |
| | Mild | 1 |
| | Nil | 0 |

## New variable added to Level of Consciousness Assessment

**Disability < 1 Year**

| Level of consciousness | | | | |
|---|---|---|---|---|
| **CHANGING BEHAVIOUR** | **ALERT** Awake and alert | **VOICE** Responds to verbal stimuli | **PAIN** Responds to painful stimuli | **UNRESPONSIVE** No response to stimuli |

New variables

**Disability > 1 Year**

| Level of consciousness | | | | |
|---|---|---|---|---|
| **NEW CONFUSION** | **ALERT** Awake and alert | **VOICE** Responds to verbal stimuli | **PAIN** Responds to painful stimuli | **UNRESPONSIVE** No response to stimuli |

## Updated Escalation Pathways

New name

Wording change

Additional high-risk patient groups

Wording changes

Added direction to notify medical staff

**Paediatric Sepsis Pathway Trigger**

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

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

**High-risk patients – have a lower threshold for requesting medical review if:**
- Infants less than 3 months
- Immunosuppression, chemotherapy, long-term steroids or asplenia
- Central venous access device, indwelling medical devices
- Unimmunised or incomplete immunisation
- Remote, delayed access to health care or patient transfer
- Recent surgery, burn, or wound
- Complex / chronic medical condition
- Culturally and or linguistically diverse
- Re-presentation (including GP)
- Family and/or clinician concern

| Sepsis recognition prompt | Clinical response |
|---|---|
| EWS 6-7 **OR** any of the following<br>• Mottled, CRT ≥3 or cold peripheries<br>• Non-blanching rash<br>• Drowsy or confused<br>• Unexplained pain<br>• Lactate 2–4 mmol/L<br>• Family and/or clinician concern is continuing or increasing | • Commence Paediatric Sepsis Pathway<br>• Request Treating Doctor or STARS Registrar review within 15 mins<br>• **State "sepsis review required"**<br>• Reviewing doctor to discuss with Senior Clinician/Consultant responsible for the patient |
| EWS 8+ **OR** any of the following<br>• Any observation in red zone<br>• AVPU score P (if unresponsive, call a CODE BLUE)<br>• Lactate >4 mmol/L<br>• BGL <3 mmol/L | • Commence Paediatric Sepsis Pathway<br>• Request Senior Clinician review within 5 mins<br>– ED: Consultant (Registrar overnight)<br>– Ward: Request MET review<br>• **State "sepsis review required"**<br>• No response within 5 mins or clinically indicated call a **CODE BLUE**<br>• Treating doctor to notify Senior Clinician/ Consultant responsible for the patient |

**Early Warning Score Escalation Pathway**
- Remain vigilant
- Complete a full set of observations
- Notify nurse in charge
- Optimise treatment
- A plan must be documented
- Reassess EWS after interventions
- Ensure Treating Team are aware of deterioration

| Score | Clinical response |
|---|---|
| 1-3 | **Senior Nursing Review**<br>• Increase frequency of observations<br>• Consider Medical Review |
| 4–5 | **Timely Medical Review**<br>• Request Treating Medical Team or STARS RMO review within 30 mins<br>• Reassess EWS within 30 mins of review<br>• Request STARS CNS review |
| 6–7 | **Urgent Treating Team Review**<br>• Request Treating Medical Team or STARS Registrar to review within 15 mins<br>• Reviewing doctor to notify Consultant (or Senior Registrar in ED overnight)<br>• Consider PCC referral<br>• Reassess EWS within 15 mins of review |
| 8+ | **Rapid Response Review**<br>• ED: Request Consultant (or Registrar overnight) to review within 5 mins. Consider PCC referral<br>• Ward: Request MET review within 5 mins<br>• MET to notify treating Consultant<br>• Assess the patient and initiate appropriate clinical care<br>• If no response within 5 mins or if clinically concerned place Code Blue Call |
| E | **Immediate Code Blue Call**<br>• 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
- You are worried about the patient

Additional instruction

Name change STARS

Specifies team member

## Targeted and specific questioning. Family /Clinician concern first in patients of concern

**Involve the family**

- **ASK** – How do you think your child is doing?
- **ASK** – Has anything changed?
- **ASK** – Are you worried your child is getting worse?

Family or clinician concern wording change and positioned as first point

**Patients of concern include those with**

- Family or clinician are worried child's condition is gettting worse or not improving
- 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
- Changes to respiratory distress

## Next Steps

- Familiarise yourself with the updated **PARROT Version 5 chart**.
- Review and adhere to local escalation pathways for children presenting with "new confusion" or "changing behaviour.“
- Participate in the updated eLearning module to reinforce key skills.

## References

*The Royal Children’s Hospital Melbourne. Guideline: Altered conscious state. [Internet]. Retrieved 2025 Feb 4. Available from Clinical Practice Guidelines : Altered conscious state (rch.org.au)*

*Silver G, Kearney J, Traube C, Hertzig M. Delirium screening anchored in child development: the Cornell Assessment for Pediatric Delirium. Palliat Support Care. 2015 Aug;13(4):1005-11. doi: 10.1017/S1478951514000947. Epub 2014 Aug 15. PMID: 25127028; PMCID: PMC5031084.*

## Policy:

Observation, Monitoring and Paediatric Acute Recognition and Response Observation Tool (PARROT)
Delirium Assessment and Management
Neurological Observations (health.wa.gov.au)