SMR110020

Holes punched as per AS2828-1999

BINDING MARGIN - NO WRITING

NH606602 200812

NSW GOVERNMENT Health

Facility: _____

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

Under 3 months

☐ Altered Calling Criteria

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ___/___/___ | M.O.

UNDER 3 MONTHS

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date

Time

AIRWAY / BREATHING

Respiratory Rate ● (breaths per minute): 90 85 80 75 70 65 60 55 50 45 40 35 30 25 20 15

Respiratory Distress: Severe | Moderate | Mild | Normal

SpO_2 ● (in any amount of O_2): 100 95 90 85 80 75 | <70 | Probe Change

Oxygen: L/min or % | Device

CIRCULATION

Heart Rate ● (beats per minute): 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60

Capillary Refill: ≥3 Seconds | <3 Seconds

Blood Pressure (mmHg) > < Systolic Blood Pressure is the trigger: 120 110 100 90 80 70 60 50 40 30 20 10

Initials

Increase Frequency of Observations | Clinical Review | Rapid Response

NSW GOVERNMENT Health

Facility: _____

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

Under 3 months

☐ Altered Calling Criteria

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ___/___/___ | M.O.

UNDER 3 MONTHS

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date

Time

DISABILITY

Level of Consciousness: Alert | Verbal/Touch | Pain | Unresponsive

Enter appropriate letter. A= Alert, V= Rousable only by voice or touch (consider GCS). P= Rousable only by central pain (conduct GCS). U=Unresponsive

Pain Score: Severe (7-10) | Moderate (4-6) | Mild (1-3) | Nil

EXPOSURE

Temperature (°C) ● (Check unit policy): 41 40.5 40 39.5 39 38.5 38 37.5 37 36.5 36 35.5 35 34.5 34

BGL

Weight

Initials

CONSIDER EARLIER ESCALATION OF PATIENTS WITH

- Chronic or complex conditions
- Post-operative
- Pre-Existing cardiac or respiratory conditions
- Opioid Infusions
- Prematurity
- Preterm or post-term neonates
- Congenital conditions

ADDITIONAL CRITERIA FOR ESCALATION ON BACK PAGE

ASSESSMENT OF RESPIRATORY DISTRESS

	MILD	MODERATE	SEVERE
Airway	• Stridor on exertion	• Stridor at rest • Partial Airway Obstruction	• New onset of Stridor • Imminent airway obstruction
Behaviour & Feeding	• Normal • Age appropriate vocalisation	• Irritability • Difficulty crying • Difficulty feeding or sucking	• Drowsy • Unable to cry • Unable to feed or suck
Respiratory Rate	• Mildly Increased	• Respiratory rate in the yellow zone	• Respiratory rate in the red zone • Decreasing (exhaustion)
Accessory Muscle Use	• None /Minimal	• Moderate recession • Tracheal Tug • Nasal Flaring • Head bobbing	• Severe Recession • Gasping • Grunting • Extreme Pallor • Cyanosis • Absent Breath Sounds
Apnoeic Episodes	• None	• Abnormal pauses in breathing	• Apnoeic episodes
Oxygen	• No oxygen requirement	• Commencement of oxygen • Increasing Oxygen requirement	• Hypoxaemia, may not be corrected by oxygen

NSW GOVERNMENT Health

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FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION

UNDER 3 MONTHS

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

Under 3 months

OTHER CHARTS IN USE

- ☐ Fluid Balance
- ☐ Neurological
- ☐ Neurovascular
- ☐ Feeding chart
- ☐ Insulin Infusion
- ☐ Pain / Epidural / Patient Control Analgesia
- ☐ Birth centile / growth chart
- ☐ Apnoea chart
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

VARIATIONS TO FREQUENCY OF OBSERVATIONS

Date							
Time							
Frequency Required							
Medical or Rapid Response Officer Name							
Signature							

ALTERATIONS TO CALLING CRITERIA
(MUST BE REVIEWED WITHIN 48 HOURS OR EARLIER IF CLINICALLY INDICATED)
Any alteration MUST be signed by a Medical Officer and confirmed by the Attending Medical Officer

Date							
Time							
Next review - date & time							
Respiratory Rate							
SpO_2							
Heart Rate							
Other							
Medical Officer name							
Medical Officer signature							
Attending Medical Officer signature							

INTERVENTIONS/COMMENTS

	DATE	TIME	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

STANDARD PAEDIATRIC OBSERVATION CHART UNDER 3 MONTHS SMR110.020

THESE INSTRUCTIONS EXPLAIN WHEN TO MAKE A CLINICAL REVIEW OR RAPID RESPONSE CALL, YOUR LOCAL ESCALATION PROTOCOL WILL EXPLAIN HOW TO MAKE A CALL

Blue Zone Actions

IF A CHILD HAS ANY ONE (1) BLUE ZONE CRITERION PRESENT YOU MUST INCREASE THE FREQUENCY OF OBSERVATIONS AS CLINICALLY APPROPRIATE, AND

1. You **MUST** initiate appropriate clinical care
2. Manage anxiety, pain and review oxygenation in consultation with the nurse in charge
3. You may call for a Clinical Review or Rapid Response at any time if worried about a patient or are unsure whether to call

You should also consider

1. Whether abnormal observations reflect deterioration in your patient
2. What is usual for your patient or if there are altered calling criteria (see front of chart)
3. Whether there is an adverse trend in observations

Additional Yellow Zone Criteria

- Increasing oxygen requirement
- Poor peripheral circulation
- Greater than expected fluid loss
- Reduced urine output or anuria (<1 ml/kg/hr)
- BGL 2-3mmol/L
- Altered mental state: Agitation, or Inconsolable
- New onset of fever > 38.5°C
- New, increasing or uncontrolled pain
- Concern by any staff or family member

IF A CHILD HAS ANY ONE (1) OR MORE CLINICAL REVIEW CRITERIA PRESENT, YOU MUST CONSULT PROMPTLY WITH THE NURSE IN CHARGE AND ASSESS WHETHER A CLINICAL REVIEW IS NEEDED (REFER TO YOUR LOCAL PROTOCOL) AND

1. You **MUST** Initiate appropriate clinical care
2. Repeat and record observations as indicated by the patient's condition, but at least within 30 minutes
3. If you called for a Clinical Review and it has not been attended within 30 minutes, you **MUST** ACTIVATE YOUR LOCAL RAPID RESPONSE
4. If the patient's observations enter the **RED** Zone while you are waiting for a Clinical Review, you **MUST** ACTIVATE YOUR LOCAL RAPID RESPONSE (See below)
5. You may call for a Clinical Review or Rapid Response at any time if you are worried about a patient or are unsure whether to call.

You should also consider

1. Whether abnormal observations reflect deterioration in your patient
2. What is usual for your patient or if there are altered calling criteria (see front of chart)
3. Whether there is an adverse trend in observations

Additional Red Zone Criteria

- New onset of stridor
- Respiratory arrest
- Cardiac arrest or circulatory collapse
- Significant bleeding
- Sudden decrease in level of consciousness of ≥2 points on GCS
- BGL < 2mmol/L or symptomatic
- New or prolonged seizure activity
- 3 or more simultaneous 'Yellow Zone' observations
- Deterioration not reversed within 1 hour of Clinical Review
- Patient deteriorates further before, during or after Clinical Review
- Serious concern by any staff or family member

IF A CHILD HAS ANY ONE (1) RED ZONE CRITERION PRESENT, CALL FOR A RAPID RESPONSE (REFER TO YOUR LOCAL ESCALATION PROTOCOL)
AND

1. You **MUST** initiate appropriate clinical care
2. Inform the Nurse in Charge
3. Repeat observations as indicated by patient's condition

CHECK THE CLINICAL RECORD FOR ADVANCE CARE DIRECTIVES OR ALTERATIONS TO CALLING CRITERIA WHICH MAY AFFECT WHETHER A CLINICAL REVIEW OR RAPID RESPONSE CALL IS INDICATED

DOCUMENTATION

1. Write interventions on the front of the chart under 'interventions'
2. Write treatment, escalation process, and outcome in the clinical record
3. Write date, signature and designation with each entry

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