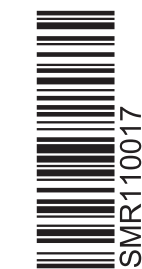

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BINDING MARGIN - NO WRITING

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NSW HEALTH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

1-4 Years

Facility: ____________________

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

1-4 Years

☐ Altered Calling Criteria

	Date	
	Time	
AIRWAY / BREATHING – Respiratory Rate ● (breaths per minute)	80, 75, 70, 65, 60, 55, 50, 45, 40, 35, 30, 25, 20, 15, 10, 5	80, 75, 70, 65, 60, 55, 50, 45, 40, 35, 30, 25, 20, 15, 10, 5
Respiratory Distress	Severe	Severe
	Moderate	Mod
	Mild	Mild
	Normal	Normal
SpO_2 ● (in any amount of O_2)	100, 95, 90, 85, 80, 75, <70	100, 95, 90, 85, 80, 75, <70
	Probe Change	Probe Change
Oxygen	L/min or %	L/min or %
	Device	Device
CIRCULATION – Heart Rate ● (beats per minute)	220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60	220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60
Capillary Refill	≥3 Seconds	≥3 Seconds
	<3 Seconds	<3 Seconds
Blood Pressure (mmHg) ˅ ˄ Systolic Blood Pressure is the trigger	150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10	150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10
	Initials	

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☐ Increase Frequency of Observations ☐ Clinical Review ☐ Rapid Response

NSW HEALTH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

1-4 Years

Facility: ____________________

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

1-4 Years

	Date	
	Time	
DISABILITY – Level of Consciousness	Alert	Alert
	Verbal	Verbal
	Pain	Pain
	Unresponsive	Unresponsive
	Enter appropriate letter. A= Alert, V= Rousable only by voice (consider GCS). P= Rousable only by central pain (conduct GCS). U=Unresponsive	
Pain Score	Severe (7-10)	Severe (7-10)
	Moderate (4-6)	Moderate (4-6)
	Mild (1-3)	Mild (1-3)
	Nil	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	41, 40.5, 40, 39.5, 39, 38.5, 38, 37.5, 37, 36.5, 36, 35.5, 35, 34.5, 34
BGL		BGL
Weight		Weight
Initials		

CONSIDER EARLIER ESCALATION OF PATIENTS WITH

- Chronic or complex conditions
- Post-operative
- Pre-Existing cardiac or respiratory conditions
- Opioid Infusions

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 • Talks in sentences	• Some / Intermittent irritability • Difficulty talking or crying • Difficulty feeding or eating	• Agitated /Confused • Drowsy • Unable to talk or cry • Unable to feed or eat
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	• Severe recession • Gasping • Grunting • Extreme pallor • Cyanosis • Absent breath sounds
Apnoeic Episodes	• None	• Abnormal pauses in breathing	• Apnoeic episodes
Oxygen	• No oxygen requirement	• Mild Hypoxaemia, corrected by oxygen • Increasing oxygen requirement	• Hypoxaemia, may not be corrected by oxygen

STANDARD PAEDIATRIC OBSERVATION CHART 1 TO 4 YEARS SMR110.017.indd 1 4/11/2010 10:49:47 AM

NSW HEALTH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Facility: ____________________

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

1-4 Years

OTHER CHARTS IN USE

☐ Fluid Balance ☐ Insulin Infusion ☐ Other __________
☐ Neurological ☐ Pain / Epidural / Patient Control Analgesia ☐ Other __________
☐ Neurovascular ☐ 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 1-4 YEARS SMR110.017

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, Combative 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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