NSW GOVERNMENT Health

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART

12 YEARS AND OVER

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR110005

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Additional RED ZONE Criteria

Cardiac or respiratory arrest
Circulatory collapse
Patient unresponsive
New onset of stridor

- Deterioration not reversed within 1 hour of Clinical Review
- 3 or more simultaneous 'Yellow Zone' observations
- Significant Bleeding
- Sudden decrease in Level of Consciousness (a drop of 2 or more points in GCS)
- New or prolonged seizures activity
- Floppy
- Blood Glucose Level < 2mmol/L or symptomatic
- Lactate ≥ 4mmol/L
- **Serious concern by family member**
- **Serious concern by you or any staff member**

- Senior Medical Officer or Nurse review within 10 minutes.
- Observations recorded at least 15 minutely.
- Must have continuous monitoring.

Additional YELLOW ZONE Criteria

- Increasing oxygen requirement
- Poor peripheral circulation (e.g. mottled/pallor)
- Greater than expected fluid loss
- Reduced urine output or anuria (< 1mL/kg/hr)
- Altered mental state: Agitation, combative, inconsolable.
- New, increasing or uncontrolled pain
- Blood Glucose Level 2 – 3 mmol/L
- **Concern by family member**
- **Concern by you or any staff member**

- Senior Medical Officer or Nurse review within 30 minutes.
- Observations recorded at least 30 minutely for the first hour and then hourly thereafter.
- Prioritise care if deteriorating.

Consider:

- Need for continuous monitoring.
- Whether changes in temperature reflects deterioration in your patient

BLUE ZONE RESPONSE

- Initiate appropriate clinical care
- Repeat and increase the frequency of observations as indicated by your patients conditions
- Consider whether there is an adverse trend in other observation

NH606613 130215

AIRWAY / BREATHING

Respiratory Rate ● (breaths per minute): 60 55 50 45 40 35 30 25 20 15 10 5

Respiratory Distress: Severe / Moderate / Mild / Normal

SpO_2 (%) ● (any amount of O_2): 100 95 90 85 80 75 <70

Oxygen: L/min or % / Device

CIRCULATION

Heart Rate ● (beats per minute): 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

Capillary Refill: ≥ 3 Seconds / <3 Seconds

Blood Pressure (mmHg) > < Systolic Blood Pressure is the trigger: 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

Blood Glucose Level: BGL

DISABILITY

GCS: EYES / VERBAL / MOTOR / TOTAL SCORE

Right Pupil: Size / Reaction

Left Pupil: Size / Reaction

Initials

Increase Frequency of Observations | Clinical Review | Rapid Response

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ALLERGY / ALERTS:

WEIGHT:

Fluid Restriction: N/A ☐ Yes ☐

Volume:

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

Pain Score: Severe (7-10) / Moderate (4-6) / Mild (1-3) / No pain / Initials

URINALYSIS

Date:			
Time:			
Specific Gravity		Nitrite	
pH		Bilirubin	
Blood		Urobilinogen	
Leukocytes		Protein	
Ketones		Glucose	
Urine HCG			
MSU/CSU/SPA	YES ☐ NO ☐		

MODIFIED PAEDIATRIC GLASGOW COMA SCALE

EYES OPEN

Spontaneously	4
To speech	3
To pain	2
None	1

BEST VERBAL RESPONSE

<2yrs	2 - 5 yrs	>5yrs	
Smiles, coos	Appropriate Words	Orientated	5
Cries but consolable	Inappropriate Words	Confused	4
Persistent cries / screams	Cries / Screams	Inappropriate Words	3
Grunts		Incomprehensible Sounds	2
None			1

BEST MOTOR RESPONSE

<1yr	>1yr	
Spontaneous	Obeys commands	6
Localises to pain		5
Flexion - withdrawal		4
Flexion - abnormal		3
Extension		2
None		1

Pupil Scale (mm)	KEY	
1	+	Reactive
2	SL	Sluggish
3	-	Non Reactive
4	C	Closed Eyes
5	T	ETT
6		
7		
8		

FLUID BALANCE CHART

INTAKE						OUTPUT					
TIME	INTRAVENOUS FLUIDS 1	INTRAVENOUS FLUIDS 2	ORAL & NG	PROG. TOTAL	IVC site	TIME	URINE	VOMIT	STOOL	OTHER	PROG. TOTAL
Totals				mLs		Totals					mLs

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	D.O.B. _____ / _____ / _____	M.O.
	ADDRESS	
12 YEARS AND OVER		
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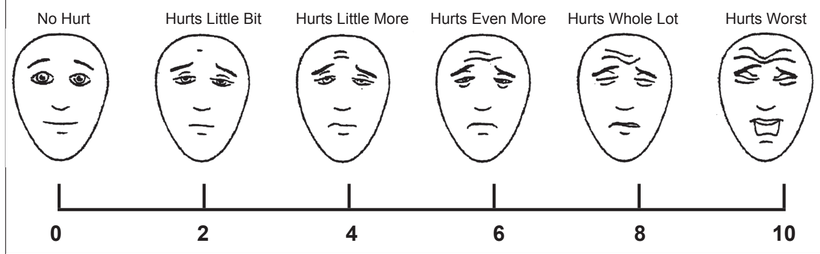
ASSESSMENT OF RESPIRATORY DISTRESS

	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 Distress	• 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 / silent chest
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

PAIN SCORE - SELF ASSESSMENT



PAIN SCORE - FLACC PAIN SCALE (BEHAVIOURAL)

	Score 0	Score 1	Score 2
FACE	No Particular expression or smile	Occasional grimace or frown	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 distractible	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

NSW GOVERNMENT Health

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART
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ALTERATIONS TO CALLING CRITERIA

Any alterations MUST be signed by a Senior Emergency Department Medical Officer
Document rationale for altering CALLING CRITERIA in the patient's health care record

DATE:		dd/MM/yy				
TIME:		hh:mm				
Next review due Date & Time		dd/MM/yy hh:mm				
	Yellow Zone	*xx-xx*				
	Red Zone	*≤ or ≥ xx*				
	Yellow Zone					
	Red Zone					
	Yellow Zone					
	Red Zone					
	Yellow Zone					
	Red Zone					
Medical Officer Name (BLOCK letters)		P. SMITH				
Medical Officer Signature		P. SMITH				

EXAMPLE

ADMISSION CHECK

Name Band: ☐ Allergy Band: Yes ☐ N/A ☐ Weight (Kg):

PRESENTING PROBLEM:

PROTOCOL COMMENCED:

IMMUNISATIONS UTD: Yes ☐ No ☐ Comment:

1. Person responsible: Relationship: Phone No:
Notified : Yes ☐ No ☐ Cannot be contacted ☐

2. Person responsible: Relationship: Phone No:
Notified : Yes ☐ No ☐ Cannot be contacted ☐

Valuables returned to the person responsible: Yes ☐ No ☐ N/A ☐

Interpreter required: No ☐ Yes ☐ Specific language:_____

Nurse (BLOCK LETTERS): Date: Time:

INJURY / NEGLECT RISK ASSESSMENT / SCREEN

1.	Inappropriate delay in presentation?	No ☐ Yes ☐
2.	Injury not explained? Injury not consistent with the stated cause? Child disclosed abuse?	No ☐ Yes ☐
3.	Injury not consistent with this child's development?	No ☐ Yes ☐
4.	Recurrent injuries or ingestions?	No ☐ Yes ☐
5.	Behaviour of parents / carers inappropriate?	No ☐ Yes ☐
6.	Are there any signs of neglect and / or a failure to follow medical advice?	No ☐ Yes ☐
7.	Child danger to self and/or others?	No ☐ Yes ☐

If YES to any answer, CONSULT AND ACTIVATE LOCAL CHILD PROTECTION RESPONSE / PROCEDURE
Refer to the MANDATORY REPORTER GUIDE

Referral made to:

ED Staff Name: **ED Staff Designation:**

ED Staff Signature: **Date:** **Time:**

PAEDIATRIC EMERGENCY DEPARTMENT OBSERVATION CHART 12 YEARS & OVER

SMR110.005

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MEDICAL ADMISSION AT TIME OF ACCEPTANCE OF CARE

PROVISIONAL DIAGNOSIS:

Attending Medical Officer's name:
Delegate's name (if applicable):
Accepted care of patient
Date:
Time:

Clinical plan explained to patient /carer Yes ☐
Clinical plan documented in progress notes Yes ☐
Admission completed by:
ED Medical Officer name:
ED Medical Officer signature:

PAEDIATRIC DEPARTURE CHECKLIST – ED TO WARD / OTHER FACILITY

NURSING

Verified that all documentation is complete
- Admission/Transfer forms/eMR Yes ☐
- Medications charted Yes ☐ N/A ☐
- Analgesia charted Yes ☐ N/A ☐
- IV fluids charted Yes ☐ N/A ☐
- Fluid balance up to date ☐
- Progress notes up to date ☐
- Risk assessments completed ☐

Diet: Eat & Drink ☐ Nil By Mouth ☐ IVT ☐ NG ☐
Infection status (incl. recent contact):
Precautions / Isolation required Yes ☐
Specify: Contact precautions / Respiratory
Parents / Guardian aware of transfer Yes ☐
Patient belongings sent to ward Yes ☐ N/A ☐
Medication sent to ward Yes ☐ N/A ☐

Ward accepting care:
Ward Nurse Accepting care:
ED Nurse Transferring name:
ED Nurse transferring sign:

MEDICAL

Medical handover given Yes ☐ No ☐
Outstanding results and actions handed over:

1.
2.
3.
4.
5.

Medical Officer accepting care name:

ED Medical Officer providing Handover
Name:
Sign:
Date:
Time:

PAEDIATRIC DEPARTURE CHECKLIST – ED TO USUAL PLACE OF RESIDENCE

Cannula / ID band removed	Yes ☐	Discharge in care of parents/guardian	Yes ☐
Discharge / referral letter	Yes ☐	Education / Fact sheet	Yes ☐
Discharge prescription	Yes ☐	Clothes / belongings	Yes ☐

AUTHORISATION FOR PAEDIATRIC DEPARTURE FROM ED

Observations within the last hour	Yes ☐	Alterations to calling criteria documented	Yes ☐ No ☐
Is the patient 'Between the Flags'	Yes ☐ No ☐	Frequency for observations documented	Yes ☐ No ☐
If not, clinical reason and plan is documented and signed	☐		

SENIOR ED NURSE

Authorised as safe for departure Yes ☐

Name (BLOCK LETTERS):

Signature:

Date: **Time:**

MEDICAL AUTHORISATION

Authorised as safe for departure Yes ☐

Name (BLOCK LETTERS):

Signature:

Date: **Time:**

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