NSW Health

STANDARD MATERNAL OBSERVATION CHART

ALL PREGNANT AND POSTNATAL WOMEN

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

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

OTHER CHARTS IN USE

- ☐ **Record of Labour**
- ☐ **Fluid Balance**
- ☐ **Clinical Pathway**
- ☐ **Pain/Epidural/Patient Controlled Analgesia**
- ☐ **Diabetes Record**
- ☐ **Vaginal loss/pad chart**
- ☐ **Drug and Alcohol Withdrawal**
- ☐ **Other** _____
- ☐ **Other** _____

MATERNAL RISK FACTORS
Is the woman at risk of deterioration?

If a woman has any risk factors for deterioration the frequency of observations must be included in an individualised care plan.

PRESCRIBED FREQUENCY OF OBSERVATIONS

As a minimum, unless documented below, maternal observations must be performed on admission then:

- *6th hourly: Antenatal inpatient*
- *4th hourly: Intrapartum inpatient*
- *Prior to discharge from birthing environment*
- *6th hourly: Postnatal inpatient with risk factors, additional criteria or abnormal observations*
- *Prior to discharge from the facility*

DATE:	dd/mm/yy				
TIME:	hh:mm				
Frequency Required	Twice daily				
Name (BLOCK letters)	P. SMITH				
Signature	P.Smith				
Designation	Midwife				
Attending Medical Officer Signature	R. Bloggs				

Alterations to calling criteria (ACC)
Acute ACC changes can be set for up to 12 hours. Chronic ACC changes apply for the episode of care
Any alterations MUST be signed by a Medical Officer and confirmed by the Attending Medical Officer
Document rationale for altering CALLING CRITERIA in the woman's health care record

DATE:		dd/mm/yy				
TIME:		hh:mm				
Next review due Date & Time		dd/mm/yy hh:mm				
ACUTE / CHRONIC		ACUTE				
	Yellow Zone					
	Red Zone					
	Yellow Zone	XXX – XXX				
	Red Zone	≤ or ≥XXX				
	Yellow Zone					
	Red Zone					
Medical Officer Name (BLOCK letters)		P. SMITH				
Medical Officer Signature		P. SMITH				
Attending Medical Officer Signature		R. Bloggs				

	Date	Time	INTERVENTIONS / COMMENTS / ACTIONS
1.	___/___/____	__:__	
2.	___/___/____	__:__	
3.	___/___/____	__:__	
4.	___/___/____	__:__	
5.	___/___/____	__:__	
6.	___/___/____	__:__	

STANDARD MATERNAL OBSERVATION CHART SMR110.013

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF THE WOMAN

Blue Zone Response to Cumulative Blood Loss

IF A WOMAN IN YOUR CARE HAS A BLUE ZONE OBSERVATION YOU MUST

1. Increase alertness and assess for continued bleeding
2. If bleeding continues refer to the management described in the NSW Health Guideline – Postpartum Haemorrhage

Yellow Zone Response

IF A WOMAN IN YOUR CARE HAS ANY YELLOW ZONE OBSERVATIONS OR ADDITIONAL CRITERIA* YOU MUST

1. Initiate appropriate clinical care
2. Repeat and increase the frequency of observations, as indicated by the woman's condition
3. Consult promptly with the **MIDWIFE / NURSE IN CHARGE** to determine if a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- What is usual for the woman and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the trend in observations suggest deterioration?
- Is there more than one Yellow Zone observation or additional criteria?
- Are you concerned about the woman?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess the woman and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned
2. Document an A-G assessment, reason for escalation, treatment and outcome in the woman's health care record
3. Inform the Attending Medical Officer that a call was made as soon as it is practicable

***Additional YELLOW ZONE Criteria**

- Increasing oxygen requirement
- Altered mental state: agitation, confusion or unexpectedly uncooperative
- Decreasing or absent deep tendon reflexes
- Anuria or urine output < 80 mLs total over 4 hours
- Blood Glucose Level 2 - 4 mmol/L
- New, increasing or uncontrolled pain
- Any risk factors, signs or symptoms of sepsis
- New Proteinuria (≥ +)
- Any current antepartum bleeding
- **Concern by the woman or family member**
- **Concern by you or any staff member**

CONSIDER IF THE WOMAN'S DETERIORATION COULD BE DUE TO SEPSIS, HYPOVOLAEMIA, CONCEALED ABRUPTION, PREECLAMPSIA OR PULMONARY EMBOLUS/DVT

Red Zone Response

IF A WOMAN IN YOUR CARE HAS ANY RED ZONE OBSERVATIONS OR ADDITIONAL CRITERIA# YOU MUST CALL FOR A RAPID RESPONSE (as per local CERS) AND

1. Initiate appropriate clinical care
2. Inform the **MIDWIFE / NURSE IN CHARGE** that you have called for a **RAPID RESPONSE**
3. Repeat and increase the frequency of observations, as indicated by the woman's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in the woman's health care record
5. Inform the Attending Medical Officer that a call was made as soon as it is practicable

#Additional RED ZONE Criteria

- Cardiac or respiratory arrest
- Airway obstruction or stridor
- Unresponsive woman
- Seizures
- Increasing oxygen requirements to maintain oxygen saturation > 90%
- Sudden decrease in Level of Consciousness (drop of 2 or more points on the GCS)
- Arterial Blood Gas: PaO_2 < 60 mmHg, or $PaCO_2$ > 60 mmHg, or pH < 7.2, or BE < -5
- Venous Blood Gas $PvCO_2$ > 65 mmHg, or pH < 7.2
- Blood Glucose Level < 2 mmol/L
- Deterioration not reversed within 1 hour of Clinical Review
- Persistent low urine output < 160 mLs over 8 hours
- Postpartum haemorrhage ≥ 500 mL - 1000 mL with continued bleeding
- Acute/severe chest pain
- Any continued/heavy antepartum bleeding
- **Serious concern by the woman or family member**
- **Serious concern by any staff member**

NSW Health

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GIVEN NAME | ☐ MALE ☐ FEMALE

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SMR110013

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

Date / Time

Patient / Family Concern — Are you worried they are getting worse? — Yes / No / Not asked

AIRWAY / BREATHING

Respiratory Rate ● — 35, 30, 25, 20, 15, 10, 5

SpO_2 % ● — 100, 95, 90, 85

Oxygen — O_2 Lpm; Device / mode

Key: RA = Room Air, NP = Nasal Prongs, FM = Simple facemask, NRB = Non Re-breather, VM = Venturi Mask

CIRCULATION

Systolic Blood Pressure (mmHg) V — 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

Diastolic Blood Pressure (mmHg) ^ — 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

Heart Rate ● — 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

DISABILITY

Neurological — A / C / V / P / U

A = Alert, C = Change in behaviour/new confusion, V = Rousable by voice (conduct GCS), P = Rousable only by pain (conduct GCS), U = Unresponsive

Initials

NH606584 270825

NO WRITING

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EXPOSURE

Temperature (°C) ● — 40, 39.5, 39, 38.5, 38, 37.5, 37, 36.5, 36, 35.5, 35

PAIN

Assess pain level (not including contraction pain)

Severe (7-10) / Moderate (4-6) / Mild (1-3) / No Pain

Lactate — ≥ 4 mmol/L / 2 to 3.9 mmol/L / < 2 mmol/L

Blood Glucose Level — BGL

Urinalysis

Protein / Blood / Ketones

POST BIRTH

4th Stage Postnatal Assessment

Fundus

F&C = Firm & Central, D = Deviated, A = Atonic

Labia/Perineum

NAD = No Abnormality Detected, S = Swelling, B = Bruised, H = Haematoma

Total blood loss at birth = antepartum + intrapartum + blood loss associated with the birth episode.
This must be documented below.

Note: the observed blood loss may not reflect the total blood loss i.e. some of the loss may be concealed in the uterus.

Measured Cumulative Blood Loss (mL) — 2000, 1900, 1800, 1700, 1600, 1500, 1400, 1300, 1200, 1100, 1000, 900, 800, 700, 600, 500, 400, 300, 200, 100

NO WRITING