NSW Health

STANDARD NEONATAL OBSERVATION CHART

POSTNATAL / SPECIAL CARE UNIT

☐ Altered Calling Criteria

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

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

ADDRESS

LOCATION

ALL OBSERVATIONS MUST BE GRAPHED — COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Time of birth _ _ : _ _

Date / Time

PARENT / FAMILY CONCERN — Are you worried your baby is getting worse? — Yes / No / Not asked

1st Set — Continue if baby has any Blue, Yellow or Red Zone observations or additional criteria and/or any Neonatal Risk factors

AIRWAY / BREATHING

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

Resp Distress: Yes / No

SpO_2 ●: 100, 95, 90, 85, < 80, Probe Change

Oxygen: L/min or %; Pressure / flow; Device / mode

CIRCULATION

Heart Rate ● (Apical) (beats per minute): 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; Diastolic; Mean

PAIN

Moderate to Severe > 3 / Minimal / No Pain ≤ 3

SCORING SCALE BASED ON THE NEONATAL PAIN AGITATION AND SEDATION SCALE (N-PASS)

Initials

Increase Frequency of Observations — Clinical Review — Rapid Response

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Time of birth _ _ : _ _

Date / Time

1st Set — Continue if Neonate has any Blue, Yellow or Red Zone observations or additional criteria and/or any Neonatal Risk factors

EXPOSURE

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

Crib temp(°C): Temperature; Type of crib

O=Open H=Humidicrib

Jaundice: < 24 hours / ≥ 24 hours

Scalp Check

Inspect and palpate the scalp at 1, 2, 4, 6, 8 and 12 hours and document findings.
Observe for diffuse boggy head swelling / oedema or increasing head circumference. Palpate for free moving fluid under the scalp that crosses suture lines. Monitor for elevation and displacement of the ear lobes, peri-orbital oedema, irritable cry or pain on handling.

- Inspection: **N** = Normal | **Br** = Bruising | **A** = Abrasion | **CS** = Caput Succedaneum | **C** = Cephalohaematoma
- Palpation: **N** = Normal | **B** = Boggy diffuse swelling / Subgaleal haemorrhage
- Head circumference (cm)

Blood Glucose Level: > 10 mmol/L; 2.6 - 10 mmol/L; 1.7 - 2.5 mmol/L; < 1.7 mmol/L

Initials

RISK ASSESSMENT

If the baby has any of the following signs of deterioration or risk factors identified escalate as per your local CERS

Does the baby have any following signs of deterioration? (tick all appropriate)

☐ Grunting ☐ Nasal flaring ☐ Chest recession ☐ Central cyanosis ☐ Lethargy / poor tone ☐ Pallor ☐ Poor feeding ☐ Irritability ☐ Jitteriness ☐ Seizures ☐ Temperature instability ☐ Abnormal movements

Is the baby at risk of any of the following? (tick all appropriate)

Respiratory distress	☐ Cord or initial pH < 7.1 / Lactate > 6 mmol/L or Apgar < 7 @ 5 minutes ☐ Caesarean section < 39 weeks	☐ Meconium stained liquor ☐ Resuscitation ≥ 10 minutes
Sepsis	☐ Maternal prolonged rupture of membranes > 18 hours ☐ Maternal group B streptococcus (GBS) ***Where risk identified refer to the Neonatal Sepsis Pathway***	☐ Maternal infection ☐ Maternal pyrexia
Encephalopathy	☐ Cord or initial pH < 7.1 / Lactate ≥ 8 or Base excess ≥ -12 mmol/L ☐ Apgar < 7 @ 5 minutes or < 6 @ 10 minutes	☐ Resuscitation ≥ 10 minutes
Hypoglycaemia	☐ Maternal history of diabetes (Type 1 or 2 or gestational) ☐ LBW < 2.5 kg or growth restriction < 10% centile	☐ Birth weight > 4.5 kg or > 90% centile ☐ < 37 weeks without other risk factors
Subgaleal haemorrhage	☐ Vacuum or forceps assisted birth ☐ Unsuccessful instrumental assisted birth	***Commence scalp checks*** **DO NOT USE HEAD COVERING**
Jaundice	☐ Blood group incompatibility or known maternal antibodies ☐ Family history of G6PD or severe jaundice in the neonate	☐ Preterm < 37 weeks ☐ Severe bruising
Maternal opiates	☐ Opiate use / administration < 4 hours prior to birth – *observations recorded every 15 minutes for the first hour, then at intervals determined by the baby's condition for at least 4 hours post birth*	
Serotonin toxicity	☐ Maternal history of SSRI / SNRI anti-depressant use	

Name (BLOCK letters): _____ **Designation:** _____

Signature: _____ **Date:** _____/_____/_____ **Time:** _ _ : _ _

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LOCATION

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Gestational Age _____ (weeks) | Birth Weight_____ (kg) | Centile _____(%)

OTHER CHARTS IN USE

- ☐ **Fluid Balance**
- ☐ **Neonatal Abstinence Screening**
- ☐ **Clinical Pathway**
- ☐ **Apnoea chart**
- ☐ **Feeding chart**
- ☐ **Centile / Growth chart**
- ☐ **Bilirubin / Jaundice**
- ☐ **Other** _____
- ☐ **Other** _____

NEONATAL RISK FACTORS
Is the baby at risk of clinical deterioration?

All babies must have a set of observations (respiratory rate, oxygen saturation, heart rate and temperature) documented and a 'Risk Assessment' (see page 3) completed before discharge from the birthing environment.

Continue recording all observations on the Standard Neonatal Observation Chart (SNOC) if the baby has any Blue, Yellow or Red Zone observations or additional criteria and/or any Neonatal risk factors.

If a clinically significant event occurs escalate care of the baby in accordance with local Clinical Emergency Response System (CERS) protocols and restart observations on the SNOC.

PRESCRIBED FREQUENCY OF OBSERVATIONS

In the absence of a clinical pathway observations must be performed at 4 hourly intervals for at risk neonates, unless documented below

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 baby'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	XX – XX				
	Red Zone	≤ or ≥XX				
	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.	__/__/__	__ : __	

STANDARD NEONATAL OBSERVATION CHART SMR110.014

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

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

Blue Zone Response

IF THE BABY HAS ANY BLUE ZONE OBSERVATIONS YOU MUST

1. Initiate appropriate clinical care
2. Increase the frequency of observations as indicated by the baby's condition
3. Fully review the baby in consultation with the **MIDWIFE / NURSE IN CHARGE**

You can make a call to escalate the care of the baby at any time if worried or unsure whether to call

Consider the following:

- What is usual for the baby and are there are any documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the abnormal observation reflect deterioration in the baby?
- Is there an adverse trend in observations?

Yellow Zone Response

IF THE BABY 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 baby's condition.
3. Consult promptly with the **MIDWIFE / NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- 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 baby?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess the baby 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 baby'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 requirements
- Systolic blood pressure 90 – 100 mmHg or 40 – 60 mmHg
- Weight loss > 10%
- Irritability, poor handling, excessive sleeping, poor feeding
- Jaundice at greater than 14 days following birth
- Temperature instability
- Has not passed saturation screening for congenital heart disease
- Bilious vomiting
- Persistent or trending lactate > 4 mmol/L
- Has not passed meconium within 48 hours
- Has not passed urine within 24 hours
- **Concern by you or any staff or family member**

CONSIDER IF THE NEONATE'S DETERIORATION COULD BE DUE TO SEPSIS, CONGENITAL HEART DISEASE, HYPOVOLAEMIA OR METABOLIC DISEASE

Red Zone Response

IF THE BABY 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 baby's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in the baby'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**
- **Circulatory collapse**
- **Unresponsive baby**
- No change or signs of improvement within 1 hour of CERS
- Apnoea
- Clinical suspicion of sepsis
- 3 or more simultaneous 'Yellow Zone' observations
- Systolic blood pressure > 100 mmHg or < 40 mmHg
- Significant bleeding
- Any seizure activity
- **Serious concern by you or any staff or family member**