SMR110020
Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING
NH606602 190924

NSW Health
NSW GOVERNMENT

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

Under 3 months

☐ 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

UNDER 3 MONTHS

Section	Parameter	Scale	Observations	Scale
		Date		Date
		Time		Time
Family / Carer Concern (Are you worried they are getting worse?)		Yes		Yes
		No		No
		Not asked		Not asked
AIRWAY / BREATHING	Respiratory Rate ● (breaths per minute)	85		85
		80		80
		75		75
		70		70
		65		65
		60		60
		55		55
		50		50
		45		45
		40		40
		35		35
		30		30
		25		25
		20		20
		15		15
	Respiratory Distress	Severe		Severe
		Moderate		Moderate
		Mild		Mild
		Normal		Normal
	SpO_2 % ●	100		100
		95		95
		90		90
		85		85
		80		80
		75		75
		< 70		< 70
		Probe Change		Probe Change
	Oxygen	L/min or %		L/min or %
		Device		Device
CIRCULATION	Heart Rate ● (beats per minute)	210		210
		200		200
		190		190
		180		180
		170		170
		160		160
		150		150
		140		140
		130		130
		120		120
		110		110
		100		100
		90		90
		80		80
		70		70
		60		60
	Capillary Refill	≥ 3 Seconds		≥ 3 Seconds
		< 3 Seconds		< 3 Seconds
	Blood Pressure (mmHg) SBP is the trigger > <	120		120
		110		110
		100		100
		90		90
		80		80
		70		70
		60		60
		50		50
		40		40
		30		30
		Initials		Initials

Increase Frequency of Observations | Clinical Review | Rapid Response

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UNDER 3 MONTHS

Section	Parameter	Scale	Observations	Scale
		Date		Date
		Time		Time
DISABILITY	Level of Consciousness	A		A
		C		C
		V		V
		P		P
		U		U
		A=Alert & appropriate for ability C=Change in behaviour/new confusion V=Rousable by voice P=Rousable by pain U=Unresponsive Conduct an A-G assessment including GCS for a score of C, V, P, or U		
	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		41
		40.5		40.5
		40		40
		39.5		39.5
		39		39
		38.5		38.5
		38		38
		37.5		37.5
		37		37
		36.5		36.5
		36		36
		35.5		35.5
		35		35
		34.5		34.5
Lactate		≥ 4 mmol/L		≥ 4 mmol/L
		2 to 3.9 mmol/L		2 to 3.9 mmol/L
		< 2 mmol/L		< 2 mmol/L
		BGL		BGL
		Weight		Weight
		Initials		Initials

Finsbury Green
DO NOT PRINT

CONSIDER EARLIER ESCALATION OF PATIENTS WITH

● Chronic or complex conditions ● Disability ● Post-operative ● Opioid Infusions ● Prematurity

ADDITIONAL CRITERIA FOR ESCALATION ON BACK PAGE

ASSESSMENT OF RESPIRATORY DISTRESS

Respiratory distress is based on the most significant feature (Severe - Moderate - Mild)

	MILD	MODERATE	SEVERE
Airway	• Stridor on exertion	• Stridor at rest	• New onset of stridor • Absent breath sounds (silent chest)
Behaviour & posture	• Normal • Can walk or crawl	• Irritability • Lethargic • Tripod sitting	• Agitated / confused / drowsy • Collapsed or exhausted
Speaking & feeding	• Normal • Talks in sentences	• Difficulty talking / vocalising or crying • Difficulty feeding or eating	• Unable to talk / vocalise or cry • Unable to feed or eat
Respiratory rate	• Respiratory rate in the Blue Zone	• Respiratory rate in the Yellow Zone	• Respiratory rate in the Red Zone • Decreasing respiratory rate (exhaustion)
Respiratory effort	• None / minimal	• Moderate recession • Tracheal tug • Nasal flaring • Head bob	• Severe recession • Seesaw / abdominal breathing • Gasping • Grunting
Apnoeic episodes	• None	• Irregular breathing pattern	• Apnoeic episodes
Oxygen	• No oxygen requirement	• Commencement of oxygen • Increasing oxygen requirement	• Hypoxaemia, may not be corrected by oxygen • Extreme pallor • Cyanosis

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ADDRESS

LOCATION

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UNDER 3 MONTHS

OTHER CHARTS IN USE

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

PRESCRIBED FREQUENCY OF OBSERVATIONS

Observations must be performed routinely at least 4th hourly, unless advised below

DATE:	dd/mm/yy				
TIME:	hh:mm				
Frequency Required	Twice daily				
Medical Officer Name (BLOCK letters)	P. SMITH				
Medical Officer Signature	P. SMITH				
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 patient's health care record

DATE:	dd/mm/yy				
TIME:	hh:mm				
Next review due Date & Time	dd/mm/yy hh:mm				
ACUTE / CHRONIC	**ACUTE**				

Vital Sign	**Zone**	**Standard Thresholds**					
Respiratory Rate	Yellow Zone	20 - 25 65 - 75					
	Red Zone	<20 >75					
SpO_2	Yellow Zone	90 - 95					
	Red Zone	<90					
Heart Rate	Yellow Zone	80 - 100 170 - 190	*xxx-xxx*				
	Red Zone	<80 >190	*≤ or ≥ xxx*				
Other	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.			

EXAMPLE

STANDARD PAEDIATRIC OBSERVATION CHART UNDER 3 MONTHS SMR110.020

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

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

Blue Zone Response

IF YOUR PATIENT HAS ANY BLUE ZONE OBSERVATIONS YOU MUST

1. Initiate appropriate clinical care
2. Increase the frequency of observations, as indicated by your patient's condition
3. Manage anxiety, pain and review oxygenation in consultation with the **NURSE IN CHARGE**
4. You can make a call to escalate the care of your patient at any time if you are worried or unsure whether to call

Consider the following:

1. What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
2. Does the abnormal observation reflect deterioration in your patient?
3. Is there an adverse trend in observations?

Yellow Zone Response

IF YOUR PATIENT 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 your patient's condition
3. Consult promptly with the **NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- What is usual for your patient 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 your patient?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess your patient 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 your patient'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
- Poor peripheral circulation
- Greater than expected fluid loss
- Reduced urine output or anuria (< 1mL/kg/hr)
- Altered mental state: Agitation, Combative or Inconsolable
- New, increasing or uncontrolled pain
- New onset of fever ≥ 38°C
- BGL 2-3mmol/L
- **Concern by you or any staff or family member**

CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, DEHYDRATION / HYPOVOLAEMIA / HAEMORRHAGE, OR AN OVERDOSE / OVER SEDATION

Red Zone Response

IF YOUR PATIENT 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 **NURSE IN CHARGE** that you have called for a Rapid Response
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient'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**
- **Patient unresponsive**
- **New onset of stridor**
- No change or signs of improvement within 1 hour of CERS
- 3 or more simultaneous 'Yellow Zone' observations
- Significant bleeding
- Sudden decrease in Level of Consciousness (a drop of 2 or more points on the GCS)
- New or prolonged seizure activity
- BGL < 2mmol/L or symptomatic
- **Serious concern by you or any staff or family member**

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