NSW Health

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

ANTENATAL SHORT STAY OBSERVATION CHART

LESS THAN 32 WEEKS

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR110042

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

Maternal Assessment

		Date / Time	1.	2.	3.	4.	Date / Time
AIRWAY / BREATHING	Respiratory Rate ●	35, 30, 25, 20, 15, 10, 5					35, 30, 25, 20, 15, 10, 5
	SpO_2% ●	100, 95, 90, 85, 80					100, 95, 90, 85, 80
CIRCULATION	Systolic Blood Pressure (mmHg) V	200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60					200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60
	Diastolic Blood Pressure (mmHg) Λ	130, 120, 110, 100, 90, 80, 70, 60, 50, 40					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					180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40
	Deep tendon reflexes A=Absent N=Normal D=Decreasing	L					L
		R					R
EXPOSURE	Temperature (°C) ●	40, 39.5, 39, 38.5, 38, 37.5, 37, 36.5, 36, 35.5, 35					40, 39.5, 39, 38.5, 38, 37.5, 37, 36.5, 36, 35.5, 35
	Initials						Initials

NH700467 110325

NSW Health

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Examination and Assessment

	1. Date: __/__/__	2. Date: __/__/__	3. Date: __/__/__	4. Date: __/__/__	
Date					Date
Time	Time: _____:_____	Time: _____:_____	Time: _____:_____	Time: _____:_____	Time
Reason for assessment					Reason for assessment
Gestation					Gestation
Weight					Weight
VTE risk assessment completed	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	VTE risk assessment completed
Abdominal Palpation					
Fundal height					Fundal height
Lie					Lie
Fetal position					Fetal position
Presentation					Presentation
Engagement					Engagement
Contractions present	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Contractions present
Fetal Assessment					
Fetal movements					Fetal movements
Fetal heart rate	FHR_____ ☐ CTG	FHR_____ ☐ CTG	FHR_____ ☐ CTG	FHR_____ ☐ CTG	Fetal Heart rate
Vaginal Examination /Assessment					
Consent	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Consent
Chaperone offered	☐ Accepted ☐ Declined	☐ Accepted ☐ Declined	☐ Accepted ☐ Declined	☐ Accepted ☐ Declined	Chaperone offered
Speculum	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Speculum
Ruptured membranes	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Ruptured membranes
Threatened premature labour Testing	☐ Positive ☐ Negative (Quant. results)_____ N/A ☐	☐ Positive ☐ Negative (Quant. results)_____ N/A ☐	☐ Positive ☐ Negative (Quant. results)_____ N/A ☐	☐ Positive ☐ Negative (Quant. results)_____ N/A ☐	Threatened premature labour Testing
PV loss colour					PV loss colour
Dilatation (cm)					Dilatation (cm)
Length (cm)					Length (cm)
Consistency					Consistency
Position of cervix					Position of cervix
Station					Station
Presenting part					Presenting part
Bishop's Score					**Bishop's Score**
Follow-up date					Follow-up date
Name (Block letters)					**Name (Block letters)**
Initials					**Initials**

The modified Bishop's score below is provided as a guide for assessment of the cervix when considering induction of labour. Use as a guide only and document score in the table above.

Cervical Assessment "Modified Bishop's score" Tool *(Assessment for induction)*

Characteristic	0	1	2	3
Dilatation (cm)	< 1	1 – 2	2 – 4	> 4
Length (cm)	> 4	2 – 4	1 – 2	< 1
Consistency	Firm	Average	Soft	-
Position of Cervix	Posterior	Middle / Anterior	-	-
Station	- 3	- 2	-1 to 0	+1 to +2

Safety Green DO NOT PRINT

NSW Health

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ANTENATAL SHORT STAY OBSERVATION CHART

LESS THAN 32 WEEKS

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REFER TO THE ANTENATAL LESS THAN 32 WEEKS EFM ALGORITHM FOR CLINICAL RESPONSE

Indication for EFM: | Gestation:

Date of EFM: _____/_____/_____ | EFM review period: _____:_____ to _____:_____

Fetal movements: | Maternal heart rate:

Is altered calling criteria in place? ☐ Yes ☐ No | Does the altered calling criteria require reviewing at this time? ☐ Yes ☐ No ☐ N/A

Uterine Activity	Baseline	Rate (bpm)	Baseline Variability	bpm	Reactivity	Decelerations
If there are any concerns refer to the NSW Health Management of Threatened Preterm Labour Guideline	☐ < 115 ☐ > 180		☐ ≤ 5 for > 90 minutes ☐ Sinusoidal/Sawtooth > 15 minutes		☐ Absent > 75 minutes	☐ Recurrent and > 30 seconds ☐ Prolonged > 3 minutes
	☐ 115 - 124 ☐ > 160 - 180		☐ ≤ 5 for > 45 minutes		☐ Absent > 45 minutes	☐ Single for > 90 seconds and ≤ 3 minutes
	☐ 125 - 160		☐ ≥ 6		☐ Present ☐ Rise in baseline of > 10 bpm associated with multiple fetal movements	☐ Nil ☐ Decelerations with an amplitude < 40 bpm for < 30 seconds with reactivity

Clinical Escalation Response

☐ **Normal** Review full clinical picture to determine if continued EFM is required	☐ **Abnormal** **Clinical Review within 30 minutes** 2 or more YELLOW ZONE features = **a Rapid Response** Time of call: _____:_____	☐ **Abnormal** **Call a Rapid Response** Time of call: _____:_____

Ask: Could there be fetal hypoxia?

Name:	Signature:	Date: ____/____/_____	Time: ____:____
Name:	Signature:	Date: ____/____/_____	Time: ____:____

Second clinician review completed and agrees with Clinical Escalation Response ☐ Yes ☐ No - Clinical Review required

Indication for EFM: | Gestation:

Date of EFM: _____/_____/_____ | EFM review period: _____:_____ to _____:_____

Fetal movements: | Maternal heart rate:

Is altered calling criteria in place? ☐ Yes ☐ No | Does the altered calling criteria require reviewing at this time? ☐ Yes ☐ No ☐ N/A

Uterine Activity	Baseline	Rate (bpm)	Baseline Variability	bpm	Reactivity	Decelerations
If there are any concerns refer to the NSW Health Management of Threatened Preterm Labour Guideline	☐ < 115 ☐ > 180		☐ ≤ 5 for > 90 minutes ☐ Sinusoidal/Sawtooth > 15 minutes		☐ Absent > 75 minutes	☐ Recurrent and > 30 seconds ☐ Prolonged > 3 minutes
	☐ 115 - 124 ☐ > 160 - 180		☐ ≤ 5 for > 45 minutes		☐ Absent > 45 minutes	☐ Single for > 90 seconds and ≤ 3 minutes
	☐ 125 - 160		☐ ≥ 6		☐ Present ☐ Rise in baseline of > 10 bpm associated with multiple fetal movements	☐ Nil ☐ Decelerations with an amplitude < 40 bpm for < 30 seconds with reactivity

Clinical Escalation Response

☐ Normal Review full clinical picture to determine if continued EFM is required | ☐ Abnormal Clinical Review within 30 minutes 2 or more YELLOW ZONE features = a Rapid Response Time of call: _____:_____ | ☐ Abnormal Call a Rapid Response Time of call: _____:_____

Ask: Could there be fetal hypoxia?

Name: | Signature: | Date: ____/____/_____ | Time: ____:____

Name: | Signature: | Date: ____/____/_____ | Time: ____:____

Second clinician review completed and agrees with Clinical Escalation Response ☐ Yes ☐ No - Clinical Review required

Indication for EFM: | Gestation:

Date of EFM: _____/_____/_____ | EFM review period: _____:_____ to _____:_____

Fetal movements: | Maternal heart rate:

Is altered calling criteria in place? ☐ Yes ☐ No | Does the altered calling criteria require reviewing at this time? ☐ Yes ☐ No ☐ N/A

Uterine Activity	Baseline	Rate (bpm)	Baseline Variability	bpm	Reactivity	Decelerations
If there are any concerns refer to the NSW Health Management of Threatened Preterm Labour Guideline	☐ < 115 ☐ > 180		☐ ≤ 5 for > 90 minutes ☐ Sinusoidal/Sawtooth > 15 minutes		☐ Absent > 75 minutes	☐ Recurrent and > 30 seconds ☐ Prolonged > 3 minutes
	☐ 115 - 124 ☐ > 160 - 180		☐ ≤ 5 for > 45 minutes		☐ Absent > 45 minutes	☐ Single for > 90 seconds and ≤ 3 minutes
	☐ 125 - 160		☐ ≥ 6		☐ Present ☐ Rise in baseline of > 10 bpm associated with multiple fetal movements	☐ Nil ☐ Decelerations with an amplitude < 40 bpm for < 30 seconds with reactivity

Clinical Escalation Response

☐ Normal Review full clinical picture to determine if continued EFM is required | ☐ Abnormal Clinical Review within 30 minutes 2 or more YELLOW ZONE features = a Rapid Response Time of call: _____:_____ | ☐ Abnormal Call a Rapid Response Time of call: _____:_____

Ask: Could there be fetal hypoxia?

Name: | Signature: | Date: ____/____/_____ | Time: ____:____

Name: | Signature: | Date: ____/____/_____ | Time: ____:____

Second clinician review completed and agrees with Clinical Escalation Response ☐ Yes ☐ No - Clinical Review required

NSW Health

ANTENATAL SHORT STAY OBSERVATION CHART

LESS THAN 32 WEEKS

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

FAMILY NAME	MRN
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Investigations and tests *(review results within health care record)*

Urinalysis

Date	1. Date: ___/___/___	2. Date: ___/___/___	3. Date: ___/___/___	4. Date: ___/___/___	Date
Time	Time: ____:____	Time: ____:____	Time: ____:____	Time: ____:____	Time
New Proteinuria ≥ +					New Proteinuria ≥ +

Pathology, imaging and swabs performed *(review results within health care record)*

Spot Urine/PCR	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Spot Urine/PCR
MSU	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	MSU
Ultrasound	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Ultrasound
FBC	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	FBC
EUC	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	EUC
Uric acid	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Uric acid
Bile acid	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Bile acid
Coags	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Coags
LFTs	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	LFTs
BGL	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	BGL
Vaginal swabs	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Vaginal swabs
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

Medications *(refer to the woman's health care record or prescription for medication details)*

Antihypertensives	☐	☐	☐	☐	Antihypertensives
Anticoagulants	☐	☐	☐	☐	Anticoagulants
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
Initials					Initials

	Date	Time	Comments regarding investigations, tests and medications *(Management plan must be recorded within the woman's health care record)*
1	___/___/____	____:____	
2	___/___/____	____:____	
3	___/___/____	____:____	
4	___/___/____	____:____	

NSW Health

ANTENATAL SHORT STAY OBSERVATION CHART

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FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
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Estimated Date of Birth ___/___/____ PARITY _ _ _ _ Date/Time Membranes Ruptured ___/___/____ __:__

Antenatal Risk Factors

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

This chart is to be used for non-admitted and short stay pregnancy assessment. Management plans must be recorded within the woman's health care record.

If this woman is admitted, observations and assessments must be recorded on the Standard Maternal Observation Chart (SMOC) or Record of Labour (ROL)

The coloured thresholds are triggers to review the woman and if required escalate her care Please refer to specific treatment guidelines for management

ALTERATIONS TO CALLING CRITERIA
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				
	Yellow Zone					
	Red Zone					
	Yellow Zone	XXX – XXX				
	Red Zone	≤ or ≥XXX				
	Yellow Zone					
	Red Zone					
	Yellow Zone					
	Red Zone					
	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
Do NOT Print

ANTENATAL SHORT STAY OBSERVATION CHART LESS THAN 32 WEEKS

SMR110.042

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

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
- Lactate 2 - 3.9 mmol/L
- **Concern by the woman or family member**
- **Concern by you or any staff member**

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: PaO2 < 60 mmHg, or PaCO2 > 60 mmHg, or pH < 7.2, or BE < -5
- Venous Blood Gas PvO2 > 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
- Acute/severe chest pain
- Any continued/heavy antepartum bleeding
- Lactate ≥ 4 mmol/L
- **Serious concern by the woman or family member**
- **Serious concern by any staff member**