SAHASSE000519

Assessments

Government of South Australia
SA Health

Rapid Detection and Response Paediatric Observation Chart

(1 - 4 years)

MR-59D

Affix patient identification label in this box

U.R. No:.....

Surname:.....

Given Name:.....

Second Given Name:.....

Hospital/Site:..... D.O.B.: ..... Sex/Gender: .....

Chart Number: Mid Arm circumference: Height: Weight:

SECTION A - GENERAL INSTRUCTIONS

Minimum set of observations – *Write in Section C*

Take observations on child (at rest and record) on admission:

- Respiratory rate, oxygen saturation SpO_2, blood pressure, pulse rate, temperature, pain score, level of consciousness
- Other observations as indicated including BGL, O_2 Flow rate, O_2 delivery method, capillary refill and level of sedation

How to record observations in Section C

Place a dot (.) in the centre of the box that includes the current observation in its range of values. Connect the new dot to the previous dot with a straight line. Write the value in the relevant box for O_2 flow rate, BGL, and also if observations fall above or below graphic parameters as indicated.

For systolic blood pressure use the symbol indicated on the graphic chart. Use the right arm (unless contraindicated) to measure blood pressure. Document cuff size and the 95th percentile for this baby/child (at Section C). Refer to Section D (Modifications) for the blood pressure limits that trigger MDT review for this baby/child.

Other Observations

Level of consciousness should be documented using the AVPU scale except for children receiving sedation and/or opioids, where a level of sedation score should be recorded in place of the level of consciousness.

Select pain assessment tool appropriate for the age, developmental level and clinical state of the child. Refer to state and/or local guidelines for pain assessment tools.

SECTION B - ASSESSMENT OF RESPIRATORY DISTRESS

Used together with Respiratory Rate to provide further information about the airway and breathing assessment.
Not all features may be present. Escalate as indicated.

	MILD	MODERATE	SEVERE
Airway	Stridor only with exertion / crying	Some stridor at rest	Biphasic or increasing severity of stridor at rest
Work of breathing	Mild chest retraction (intercostal and/or suprasternal recession)	Moderate chest retraction (moderate intercostal and/or suprasternal recession) Tracheal tug / head bob / nasal flaring may be present	Severe chest retraction (marked intercostal, suprasternal and sternal recession) Tracheal tug / head bob / nasal flaring Grunting / gasping
Colour	Pink	Pallor	Dusky, mottled, cyanotic, extreme pallor
Behaviour / feeding	Normal behaviour / interactive No difficulty feeding Talks in sentences Loud cry	Intermittent irritability / difficult to console / more tired than usual Difficulty feeding Some difficulty talking (words only)	Agitated / confused or lethargic / looks exhausted Refuses / unable to feed Unable to talk or cry (too breathless)
Apnoea	Transient No desaturation	Transient with brief desaturations	Apnoea that is recurrent or prolonged or requires intervention
Oxygen	No oxygen requirement	New or increasing oxygen requirement	Hypoxaemia (SpO_2 < 90% on Oxygen, HHHFNO or CPAP)

SA Health
Revised
April 2022

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SECTION G - RESPONSE CRITERIA AND ACTIONS TO TAKE

ALWAYS CHECK CURRENT MODIFICATIONS

MEDICAL EMERGENCY RESPONSE (MER) CALL

RESPONSE CRITERIA - If one or more observations are in the purple zone, or one or more of the following are occurring;		ACTIONS REQUIRED
• You are worried about the patient • A patient or consumer is worried	• Respiratory or cardiac arrest • Threatened airway • Significant bleeding • Unexpected or uncontrolled seizure • Consider for delayed MDT review (> 30 minutes)	• Place emergency call and specify location • Initiate basic/advanced life support • Notify senior doctor responsible for patient • Increase frequency of observations post intervention. Take advice from MER team

MULTI DISCIPLINARY TEAM (MDT) REVIEW *(Minimum team of registered nurse/midwife and medical practitioner)*

RESPONSE CRITERIA - If one or more observations are in the red zone, or one or more of the following are occurring;		ACTIONS REQUIRED
• You are worried about the patient • A patient or consumer is worried	• Poor peripheral circulation • Greater than expected fluid loss • Urine output < 1ml/kg/hr over 4 hours or patient has not voided for 12 hours • New or increase in O_2 flow rate Escalate to **MER call** if there are 3 or more observations in red zone	• MDT review must occur within 30 minutes (Rural Hospitals refer to local guidelines) or escalate to MER call • Increase frequency of observations (minimum hourly). Escalate if there are ongoing fluctuations. • Review SpO_2 and O_2 flow rate requirements

REGISTERED NURSE OR REGISTERED MIDWIFE *(and notify Shift Coordinator)*

RESPONSE CRITERIA - If one or more observations are in the yellow zone, or one or more of the following are occurring;		ACTIONS REQUIRED
• You are worried about the patient • A patient or consumer is worried	• Poor peripheral circulation • New or unexplained behavioural change • Unrelieved or unexpected pain Escalate to **MDT review** if there are 3 or more observations in yellow zone	• Registered nurse/midwife review must occur within 30 minutes, or escalate to MDT review • Increase frequency of observations • Manage anxiety, pain and other symptoms • Review SpO_2 and O_2 flow rate requirements

SECTION H - SEDATION SCORE

Score	Descriptor	Stimulus	Response	Duration
3	Difficult to rouse	Pain, shoulder squeeze	Brief eye opening OR any movement OR no response	N/A
2	Easy to rouse, difficulty staying awake	Voice, light touch	Eye opening and eye contact	< 10 seconds
1	Easy to rouse	Voice, light touch	Eye opening and eye contact	≥ 10 seconds
0	Awake, alert when approached	N/A	N/A	N/A

SECTION C - OBSERVATION CHART

Date																			
Time																			
Respiratory Rate *(breaths/min)*	Write ≥ 60																		Write ≥ 60
	50 - 59																		50 - 59
	45 - 49																		45 - 49
	40 - 44																		40 - 44
	35 - 39																		35 - 39
	30 - 34																		30 - 34
	25 - 29																		25 - 29
	20 - 24																		20 - 24
	17 - 19																		17 - 19
	Write ≤ 16																		Write ≤ 16
Respiratory Distress	Severe																		Severe
	Moderate																		Moderate
	Mild																		Mild
	Nil																		Nil
O_2 Saturation (SpO_2) (%)	≥ 95																		≥ 95
	92 - 94																		92 - 94
	90 - 91																		90 - 91
	Write ≤ 89																		Write ≤ 89
O_2 Flow Rate	Write value *(L/min)*																		Write value *(L/min)*
Delivery Method	*Write*																		*Write*
Probe Change	*Tick*																		*Tick*
Pulse Rate *(beats/min)*	Write ≥ 170																		Write ≥ 170
	160s																		160s
	150s																		150s
	140s																		140s
	130s																		130s
	120s																		120s
	110s																		110s
	100s																		100s
	90s																		90s
	80s																		80s
	70s																		70s
	Write ≤ 69																		Write ≤ 69
Capillary Refill	Write ≥ 3 sec																		Write ≥ 3 sec
	< 3 sec																		< 3 sec
Blood Pressure *(mmHg)*	Write ≥140																		Write ≥140
	130s																		130s
	120s																		120s
	110s																		110s
	100s																		100s
	90s																		90s
	80s																		80s
	70s																		70s
	60s																		60s
	50s																		50s
	40s																		40s
	Write ≤ 39																		Write ≤ 39
Temp *(°C)*	Write ≥ 39.1																		Write ≥ 39.1
	38.6 - 39.0																		38.6 - 39.0
	38.1 - 38.5																		38.1 - 38.5
	37.6 - 38.0																		37.6 - 38.0
	37.1 - 37.5																		37.1 - 37.5
	36.6 - 37.0																		36.6 - 37.0
	36.1 - 36.5																		36.1 - 36.5
	35.6 - 36.0																		35.6 - 36.0
	35.1 - 35.5																		35.1 - 35.5
	Write ≤ 35.0																		Write ≤ 35.0
Level of Consciousness *(wake patient before scoring)*	Alert																		Alert
	Verbal																		Verbal
	Pain																		Pain
	Unresponsive																		Unresponsive
Level of Sedation *For children receiving sedation and/or opioids only (wake patient before scoring)*	3																		3
	2																		2
	1																		1
	0																		0
Pain Score FLACC ☐ Faces ☐ *(Please tick)*	8 - 10																		8 - 10
	5 - 7																		5 - 7
	0 - 4																		0 - 4
BGL	Write (mmol/L)																		Write (mmol/L)
Initials																			

95th Percentile: _____
Cuff Size: _____

Use systolic blood pressure as trigger for response

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SECTION D - MODIFICATIONS

A Medical Officer must write and review any **Modifications.** These are any observation(s) for this patient within a specified time that modify the trigger point for escalation. Refer to the local procedure(s) for instructions on documenting and altering Modifications.

	Modification 1	Modification 2	Modification 3	Modification 4
Start Date and Time				
Finish Date and Time				
Observation(s)				
Triggers for MDT review				
Triggers for MER call				
Doctor's Signature				
Doctor's Name *(print)*				
Doctor's Designation				
Nurse/Midwife Signature				
Nurse/Midwife Name *(print)*				
Nurse/Midwife Designation				

SECTION E – FREQUENCY OF OBSERVATIONS

Observations should be performed routinely at least 4 hourly unless advised below. Refer to local procedure for who can alter frequency.

Date	(e.g) 06/04/2021	/ /	/ /	/ /	/ /	/ /	/ /
Frequency	2/24						
Name/Designation	Smith RN						

SECTION F - INTERVENTION OR REVIEW DONE (INCLUDING MDT OR MET CALL)

Date / Time	Intervention or review (e.g. Urine Output, increase frequency BGL's, O_2 changes etc)	Patient family/ carer concern	Physical state change	Mental state change	Name / Signature
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

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