MR59J RDR Newborn 0-7 days

RDR Neonatal Observation Chart (Standard newborn 0-7 days) (MR59J)

Date of Birth	Time of Birth	Birth Weight	Gestational Age	Apgar Score
__ __/__ __ /__ __ __ __	__ __ :__ __	____________ gms	____________ wks	____________

Date / time	
Respiratory Rate (RR) *(breaths/min)*	Write > 80
	70 - 79
	60 - 69
	50 - 59
	40 - 49
	30 - 39
	20 - 29
	Write < 20
Signs of Respiratory Distress	nasal flaring (NF), grunting (G), recession (R), stridor (S), head bob (H)
	Yes
	No
Heart Rate (HR) *(beats/min)*	Write ≥ 190
	180 -189
	170 - 179
	160 - 169
	140 - 159
	120 - 139
	100 - 119
	90 - 99
	80 - 89
	Write < 80
Temperature *(T°C)*	Write ≥ 38
	37.5 – 37.9
	37 – 37.4
	36.5 – 36.9
	36 – 36.4
	35.5- 35.9
	Write < 35.5

Assessments

Date / time	
Blood Glucose Level *(mmol/L)*	Write ≥ 8
	2.6 - 7.9
	2.1 - 2.5
	1.5 - 2.0
	Write < 1.5

Date / time	
Conscious State	Alert/active
	Sleeping but wakes to feed
	Irritable/jittery
	Lethargic
	Unresponsive
Bile Stained Vomit	Yes
Subgaleal Haemorrhage	Yes
	No
Head Circumference *(cm)*	

Additional Observations (e.g. Cot Temp. Bilirubin, O_2 Saturation, Blood Pressure, Inspired O_2)

Interventions or Review (Refer opposite Page)	

Rapid Detection and Response Neonatal Observation Chart

(Standard newborn 0-7 days) (MR59J)

Attached to breast code:
A = mother unassisted – baby attached correctly independently
B = attached by mother – verbally guided by midwife
C = mother assisted – hands on assistance required from midwife

Affix patient identification label in this box

UR No: ....
Surname: ....
Given Name: ....
Second Given Name: ....
D.O.B: .... Sex: .... (M / F)

Suck Score:
0 = no sucking effort, sleepy
1 = shallow sucks, uncoordinated
2 = sucked occasionally
3 = correct attachment, deep, frequent, effective sucking

Dirty Nappies BO:
B = black
GB = green / black
Y = yellow
W = watery
R = blood

Swallow Score:
0 = no swallowing
1 = swallowing infrequently
2 = swallowing occasionally with let-down
3 = correct attachment, deep, frequent

Wet Nappies PU:
\+ = slightly damp
++ = wet
+++ = saturated
U = urates

Feeding codes
B/F = breast feeding
A/F = artificial feeding
EBM = expressed breast milk
FF = finger feeding
CF = cup feeding
BOT = bottle feeding

Maternal Sedation Score		
0 - Awake	1 - Sedated, easy to rouse	2 - Sedated, difficult to rouse
Observe feed as per RDR	Do not leave the mother unattended when feeding or holding neonate	Do not leave the mother unattended when feeding or holding neonate

Date & Time / **Post Natal Day**	**Attached to Breast Code** *(see above)*	**Maternal Sedation Score**	**Suck Score** *(see above)* L	R	**Swallow Score** *(see above)* L	R	**Observe Feed for Signs of Milk Transfer** *(minimum observation of 1 feed per shift)* • Change in frequency of suckling with letdown/milk ejection reflex. • Noticeable jaw/temple movement associated with deep, frequent, effective sucking • Episodes of frequent swallowing with occasional pauses. • Audible swallowing. Rule off previous 24 hours and total feeds, BO and PU. If commenting on feeds and wellbeing, then **print name / sign / designation**	**Other nutrition** Type	Method	Volume	**EBM & Formula Milk Feed** *Two staff to check & Sign*	**Nappies** *(see above)* Dirty	Wet	**Vomits**

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Rapid Detection and Response Neonatal Observation Chart

(Standard newborn 0-7 days) (MR59J)

Hospital: ....

Affix patient identification label in this box

UR No: ....
Surname: ....
Given Name: ....
Second Given Name: ....
D.O.B: .... Sex: .... (M / F)

Chart Number:

General Instructions

This chart is intended for monitoring and screening newborn neonates. The 0-3 month old RDR chart (59B) is for sick neonates in a paediatric ward.

- **All** neonates are to have:
  - A risk assessment at birth, with a minimum of hourly observations for the first four hours of life and before discharge.
  - If a baby is admitted from home, commence the chart after the first four hours, beyond the black dividing line.
  - Minimum observations include: Respiratory Rate, Heart Rate and Temperature taken with the neonate at rest.
  - Oximetry Screening to be performed on all neonates between 4 and 12 hours of age.
- Additional observations are to be taken, based on the clinical condition, risk assessment, deterioration or concern by parents or staff.
- Whenever an observation falls within a shaded area, you must initiate the actions required for that colour.
- Management of risks will be guided by clinical assessment, SA PPG's and local procedure or protocol.
- Country hospitals should have a low threshold for consulting tertiary services.

Assessments

Medical Emergency Response (MER) Call

Response Criteria
1. Neonates requiring immediate medical attention
2. Respiratory or cardiac arrest or seizure activity
3. Any observation in the purple zone
4. You or a parent/family member is worried about the neonate

Actions Required ASAP
1. Place emergency call and specify location
2. Initiate basic/advanced life support
3. Notify senior doctor responsible for patient

Multi Disciplinary Team (MDT) Review

(Minimum of a registered nurse/midwife and medical doctor)

Response Criteria
1. Any observation in a red zone
2. You or a parent/family member is worried about the neonate

Actions Required
1. MDT to review patient within 15 minutes (Country Hospitals to refer to local guidelines)
2. Increase frequency of observations
3. If MDT not attended within 15 minutes escalate to Neonatal Consultant. (Country hospitals refer to local guidelines).

*** 3 or more observations in the red zone, escalate to MER Call**

RM/RN Review & Notify Shift Coordinator

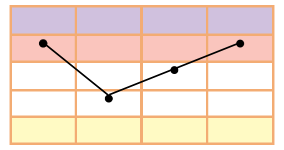
Response Criteria
1. Any observation in a yellow zone
2. You or a parent/family member is worried about the neonate

Actions Required
1. Registered nurse/midwife must review the neonate
2. Increase frequency of observations
3. If not reviewed within 30 minutes, escalate to MDT review

*** 3 or more observations in the yellow zone, escalate to MDT Review**

Show the Trend: Plot the Dot – Join the Line

Look for worsening trends and report these. When graphing observations, place a dot in the box and connect it to the previous dot with a straight line.



SA Health
Created May 2019

RDR Neonatal Observation Chart (Standard newborn 0-7 days) MR59J

C M Y K

MR59J RDR Newborn 0-7 days

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(Standard newborn 0-7 days) (MR59J)

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Given Name: ....
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RISK ASSESSMENT TO DETERMINE THE NEED FOR MORE FREQUENT OBSERVATIONS

Respiratory Distress / Depression ☐ No Risk	☐ Cord or initial pH < 7.1 ☐ Apgar score < 6 at 5 minutes ☐ Maternal systemic opiates for pain relief < 4 hours prior to birth ☐ Maternal General Anaesthetic ☐ Received Naloxone
Preterm ☐ No Risk	☐ < 37 weeks
Sepsis ☐ No Risk	☐ Maternal prolonged rupture of membranes >18 hours without adequate antibiotic prophylaxis ☐ Maternal GBS positive with antibiotics < 4 hours before delivery ☐ Maternal pyrexia/infection (≥ 38°C)
Hypoglycaemia ☐ No Risk	☐ Birth weight < 2.5kg ☐ Small for gestational age ☐ Maternal diabetes ☐ Maternal Beta blockers etc.
Birth Trauma ☐ No Risk	☐ Instrumental delivery – risk of subgaleal haemorrhage (mass over the occiput that crosses the midline) ☐ Other ....
Jaundice ☐ No Risk	☐ Blood group incompatibility or known maternal antibodies ☐ Family history of G6PD or severe jaundice in the newborn
Other ☐ No Risk	☐ .... ☐ ....
Actions Planned	

Name: ....
Signature: ....
Designation: ....
Date: .... Time: ....

Interventions or review

If you administer an intervention or review, record here and note letter in intervention row on page 2 in appropriate time column.

		Name, Sign, Designation
A		
B		
C		

NEONATAL SCREENING TEST COMPLETE

Card Number: ....
Date: .... Time: ....
Name: ....
Signature: ....
Designation: ....

HEARING SCREENING RESULT – to be completed by screener

Pass (P) Refer (R) Decline (D) No Test (N)	Refer to Child and Family Health Service	Neonatal Hearing Screening Card Number
LEFT | RIGHT	Yes (Y) No (N)	

Name: ....
Signature: ....
Designation: ....
Date: .... Time: ....

OXIMETRY SCREENING

Date/Time				
Site	Rt Hand	Foot	Rt Hand	Foot
≥ 98				
95 - 97				
90 - 94				
Write < 90				
Name:				
Signature:				
Designation:				

Indicate values as X or write value if < 90%
Subsequent oximetry screen as per physician request or local policy.
A medical review is required if there is > 3% variation between the hand and foot screening.

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__ __ /__ __ /__ __ __ __	__ __ :__ __	______ gms	______ wks	______

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Assessments

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			L	R	L	R		Type	Method	Volume	Two staff to check & Sign	Dirty	Wet	

Observe Feed for Signs of Milk Transfer
(minimum observation of 1 feed per shift)
- Change in frequency of suckling with letdown/milk ejection reflex.
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- Audible swallowing.

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