NSW GOVERNMENT Health

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

5 - 11 Years

☐ 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

		Date / Time	Date / Time
AIRWAY / BREATHING	Respiratory Rate ● (breaths per minute)	60 55 50 45 40 35 30 25 20 15 10 5	60 55 50 45 40 35 30 25 20 15 10 5
	Respiratory Distress	Severe / Moderate / Mild / Normal	Severe / Mod / Mild / Normal
	SpO_2 % ●	100 95 90 85 80 75 <70 Probe Change	100 95 90 85 80 75 <70 Probe Change
	Oxygen	L/min or % / Device	L/min or % / Device
CIRCULATION	Heart Rate ● (beats per minute)	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
	Capillary Refill	≥ 3 Seconds / < 3 Seconds	≥ 3 Seconds / < 3 Seconds
	Blood Pressure (mmHg) > < SBP is the trigger	160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10	160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10
	Initials		Initials

Increase Frequency of Observations | Clinical Review | Rapid Response

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		Date / Time	Date / Time
DISABILITY	Level of Consciousness	Alert / Verbal / Pain / Unresponsive	Alert / Verbal / Pain / Unresponsive
		Enter appropriate letter. A = Alert, V = Rousable only by voice (consider GCS). P = Rousable only by central pain (conduct GCS). U = Unresponsive	
	Pain Score	Severe (7-10) / Moderate (4-6) / Mild (1-3) / Nil	Severe (7-10) / Moderate (4-6) / Mild (1-3) / Nil
EXPOSURE	Temperature (°C) ● (Check unit policy)	41 40.5 40 39.5 39 38.5 38 37.5 37 36.5 36 35.5 35 34.5 34	41 40.5 40 39.5 39 38.5 38 37.5 37 36.5 36 35.5 35 34.5 34
	BGL		BGL
	Weight		Weight
	Initials		Initials

CONSIDER EARLIER ESCALATION OF PATIENTS WITH

- Chronic or complex conditions
- Post-operative
- Pre-Existing cardiac or respiratory conditions
- Opioid Infusions

ADDITIONAL CRITERIA FOR ESCALATION ON BACK PAGE

ASSESSMENT OF RESPIRATORY DISTRESS

	MILD	MODERATE	SEVERE
Airway	• Stridor on exertion	• Stridor at rest • Partial airway obstruction	• New onset of stridor • Imminent airway obstruction
Behaviour & Feeding	• Normal • Talks in sentences	• Some / intermittent irritability • Difficulty talking or crying • Difficulty feeding or eating	• Agitated / confused • Drowsy • Unable to talk or cry • Unable to feed or eat
Respiratory Rate	• Mildly increased	• Respiratory rate in the Yellow Zone	• Respiratory rate in the Red Zone • Decreasing (exhaustion)
Accessory Muscle Use	• None / minimal	• Moderate recession • Tracheal tug • Nasal flaring	• Severe recession • Gasping • Grunting • Extreme pallor • Cyanosis • Absent breath sounds
Apnoeic Episodes	• None	• Abnormal pauses in breathing	• Apnoeic episodes
Oxygen	• No oxygen requirement	• Mild hypoxaemia, corrected by oxygen • Increasing oxygen requirement	• Hypoxaemia, may not be corrected by oxygen

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OTHER CHARTS IN USE

- ☐ **Fluid Balance**
- ☐ **Neurological Observation**
- ☐ **Neurovascular**
- ☐ **Insulin Infusion**
- ☐ **Pain / Epidural / Patient Control Analgesia**
- ☐ **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				

EXAMPLE

ALTERATIONS TO CALLING CRITERIA
MUST BE REVIEWED WITHIN 48 HOURS OR EARLIER IF CLINICALLY INDICATED
Any alterations MUST be signed by a Medical Officer and confirmed by 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				

Vital Sign	Zone	Standard Thresholds					
Respiratory Rate	Yellow Zone	10 - 15 35 - 50					
	Red Zone	< 10 > 50					
SpO_2	Yellow Zone	90 - 95					
	Red Zone	< 90					
Heart Rate	Yellow Zone	60 - 70 140 - 160	xxx-xxx				
	Red Zone	< 60 > 160	≤ 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.			

STANDARD PAEDIATRIC OBSERVATION CHART 5-11 YEARS SMR110.018

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 > 38.5°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**
- Deterioration not reversed within 1 hour of Clinical Review
- 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
- Lactate ≥ 4mmol/L
- **Serious concern by you or any staff or family member**