# **Clinical Governance Unit**

Revisions to the Paediatric Rapid Detection and Response Observation Charts



# FACT SHEET

# BACKGROUND

The purpose of Rapid Detection and Response (RDR) Paediatric Observation Charts is to assist clinicians to recognise early signs of physical deterioration, and take appropriate action, including triggering a review by other clinicians. In some cases, this will need to be a Medical Emergency Response (MER / MET / CodeBlue).

RDR charts were first introduced to SA Health in July 2012. Adult RDR charts were reviewed in 2020 and the suite of Paediatric charts have now been revised in 2022.

Feedback was received from all Local Health Networks (LHN's) using the paediatric charts and the review process was assisted by a workgroup of the Child and Adolescent Health Community of Practice (CAH-CoP). All feedback provided by LHNs, individuals and small expert groups has been considered and used to inform the revised version of the paediatric charts.

# FORM REVISIONS

The following information outlines the revisions made to each section of the chart.

## 1. Layout / structure of the forms

Sections moved for improved usability and inclusion of additional information and to align more closely with the layout of the adult RDR charts.

- > Modifications table now on page 3, opposite where the observations are documented, rather than having to turn the chart over.
- > Title for charts Under 3 months now 0-3 months. 12+ years now 12-17 years

## 2. Local / state guidelines

Refer to state guidelines and/or local procedures for guidance on:

- > Frequency of observations and who can alter these
- > Modifications level of doctor who can write/alter them
- Tools used for assessing pain score. Pain scales not included in charts SA Health website for FLACC scale or Faces scale Acute Pain Management and Opioid Safety in Children (sahealth.sa.gov.au) - Paediatric Clinical Practice Guidelines | SA Health
- Tools for assessing Level of consciousness use AVPU assessment tool OR Level of sedation use Sedation Score descriptor at Page 4 (Section H)

> Documenting Blood Pressure 95th percentile, BP cuff size, mid arm circumference, oxygen flow rate, oxygen delivery method and oximeter probe change

## 3. General instructions - Section A: Page 1

Record the Chart number, Mid Arm circumference (cm), Height (cm) and Weight (in kilograms) at the top of page 1.

General Instructions include:

- > the minimum set of observations and additional observations to be taken as indicated.
- > how to record observations in Section C
- > information on other observations systolic blood pressure

Chart Number:	Mid Arm circumference:	Height:	Weight:
	SECTION A - GENERAL	INSTRUCTIONS	
	a <mark>tions – <i>Write in Section C</i> Id (at rest and record) on admissio</mark>	n:	
<ul> <li>Respiratory rate, oxyge consciousness</li> </ul>	n saturation $\operatorname{SpO}_2$ , blood pressure,	pulse rate, temperatur	re, pain score, level of
<ul> <li>Other observations as i sedation</li> </ul>	ndicated including BGL, O <sub>2</sub> Flow ra	ate, O <sub>2</sub> delivery method	d, capillary refill and level of
Other Observations			
Level of consciousness sl and/or opioids, where a le	hould be documented using the Average and the Average and the rest of sedation score should be rest.	/PU scale <u>except</u> for cl corded in place of the	hildren receiving sedation level of consciousness.
	ool appropriate for the age, develop elines for pain assessment tools.	pmental level and clinio	cal state of the child. Refer
For systolic blood pressu	re use the symbol in <u>dicated on the</u>	e graphic chart. Use th	e right arm (unless
contraindicated) to meas	ure blood pressure. Document cuf ection D (Modifications) for the blo	f size and the 95th per	rcentile for this baby/child

## 4. Assessment of respiratory distress - Section B: Page 1

This section is now on page 1 and each assessment category is clearly coloured to match the relevant escalation response.

- > Respiratory pattern has been replaced with 2 categories 'Colour' and 'Apnoea'
- > Now 6 assessments used with Respiratory Rate to assess respiratory distress
- > Work of breathing' title replaces 'Accessory muscle use
- > Assessment categories coloured to match the relevant escalation response
- Other changes airway no secretions just stridor, work of breathing chest retraction, behaviour/ feeding – crying, no tube feeds, Apnoea and Oxygen - more detail, hypoxaemia defined as SpO2<90% on Oxygen, HHHFNO or CPAP - purple zone

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 <sub>2</sub> < 90% on Oxygen, HHHFNO or CPAP)	

## 5. Observation chart - Section C: Page 2

Changes to the parameters are highlighted with snips in each observation type below.

## **Respiratory rate**

> Respiratory Rate is used together with the Assessment of Respiratory Distress (Section B)

MR Form	Previous chart	Revised chart
	Respiratory Rate	Respiratory Rate
MR-59B		
0 - 3 months	Write ≥ 80 $75 - 79$ $70 - 74$ $65 - 69$ $60 - 64$ $55 - 59$ $50 - 54$ $45 - 49$ $40 - 44$ $35 - 39$ $30 - 34$ $25 - 29$ $20 - 24$ $15 - 19$ Write ≤ 14	Write $\geq 80$ 75 - 79         70 - 74         65 - 69         60 - 64         55 - 59         50 - 54         45 - 49         40 - 44         35 - 39         30 - 34         25 - 29         20 - 24         Write $\leq$ 19

MR Form	Previous chart	Revised chart	
	Respiratory Rate	Respiratory Rate	e
MR-59C	Write ≥ 75	Write ≥ 70	
3 months –	70 - 74	65 - 69	
1 year	65 - 69	60 - 64	
.,	60 - 64	<b>55 - 59</b>	
	55 - 59		
	50 - 54	50 - 54	
	45 - 49	45 - 49	
	40 - 44	40 - 44	
	35 - 39 30 - 34	35 - 39	
	25 - 29	30 - 34	
	20 - 24	25 - 29	
	15 - 19	20 - 24	
	Write ≤ 14	Write≤ 19	
MR-59D	Write ≥ 60	Write ≥ 60	
1 – 4 years	50 - 59	50 - 59	
_	45 - 49	45 - 49	
	40 - 44	40 - 44	
	35 - 39		
	30 - 34	35 - 39	
	25 - 29	30 - 34	
	20 - 24	25 - 29	
	17 - 19	20 - 24	
		• 17 - 19	
	12 - 16 Write ≤ 11	Writ ≤ 16	
MR-59E	Write ≥ 50	 → Write ≥ 45	
5 – 11 years	45 - 49	40 - 44	-
J - TT years	40 - 44		
	35 - 39	35 - 39	
	30 - 34	30 - 34	
		25 - 29	
	25 - 29	20 - 24	
	<u>20 - 24</u> 15 - 19	15 - 19	1
	10 - 14	11 - 14	1
	Write ≤ 9	Write ≤ 10	
MR-59F	Write ≥ 40	 ► Write 35	
12 - 17 years			
,, <b>,</b>	35 - 39	30 - 34	
	30 - 34	26 - 29	
	26 - 29	21 - 25	
	21 - 25	16 - 20	1
	16 - 20		
	11 - 15 -	• 13 - 15	
	8 - 10	10 - 12	
	Write ≤ 7	Write≤9	1
	WHICE 7		-

## **Respiratory Distress**

> No change to graph - Refer to Assessment of Respiratory Distress - (Section B) Page 1

## Oxygen Saturation SpO2 (%)

> No change to graph

## **Oxygen Flow Rate, Delivery Method and Probe change**

#### All charts

- > Write in oxygen flow rate (L/min) and delivery method
- > Tick box added tick to indicate oximeter probe change time

0 <sub>2</sub> Flow Rate	Write value (L/min)
Delivery Method	Write
Probe Change	Tick

## Pulse Rate (beats/min)

MR Form	Previous chart	Revised chart
	Pulse rate	Pulse rate
MR-59B 0 - 3 months	Write ≥ 180           170s           160s           150s           140s           130s           120s	Write ≥ 190           180s           170s           160s           150s           140s
	110s 100s 90s 80s 70s 60s Write ≤ 59	130s 120s 110s 100s ₩rfte ≤ 99

Significant reduction in tolerance for bradycardia in a baby 0-12 months:

#### Change of 30 - 40bpm

MER Call for pulse rate:

- ≤99 for 0-3month old and
- $\leq$  89 for 3months-1year old (was  $\leq$  59)

MR-59C	Write $\ge 180$ Write $\ge 180$
3 months -	170s 170s
1 year	160s 150c
i year	1505
	140s 150s
	130s 140s
	120s 130s
	110s
	100s 120s
	90s 110s
	80s 100s
	70s 90s
	60s
	Write $\leq 59$ Write $\leq 89$

MR Form	Previous chart	Revised chart
	Pulse rate	Pulse rate
MR-59D		
1 – 4 years	Write ≥ 180	Write ≥ 170
,	170s	160s
	160s	150s
	150s	140s
	140s	
	130s	130s
	120s	120s
	110s	110s
	100s	100s
	90s 80s	90s
	70s	80s
	60s	70s
	Write ≤ 59	Write ≤ 69
MD 505		
MR-59E		
5 – 11 years	Write ≥ 170	Write≥ 150
	160s	140s
	150s	130s
	140s 130s	120s
	120s	
	110s	110s
	100s	100s
	90s	90s
	80s	80s
	70s	> 70s
	<u>60s</u>	
	50s	► 60s
	Write ≤ 49	Write ≤ 59
MR-59E		
12 – 17 years	Write ≥ 160	Write 140
,	150s	
	140s	130s
	130s	120s
	120s	▶ 110s
	110s	100s
	100s	90s
	90s	
	80s	80s
	70s	70s
	60s	60s
	50s	► 50s
	40s	Write 49
	Write ≤ 39	Wing 2 49

## **Capillary Refill**

#### All charts

> revised to 3 seconds

MR	Previous chart	Revised chart	
Form	Capillary Refill	Capillary Refill	
All charts	Capillary Refill (seconds)Write ≥ 2 sec< 2 sec	Capillary Refill < 3 sec	

## **Blood Pressure (mm/Hg)**

#### Changes:

- > Addition of space to record mid-arm circumference and height Section A: Page 1
- Space to record BP cuff size and 95th percentile blood pressure for the baby/child. (This is optional additional information – refer to local procedures for recording)
- > RN/RM Review trigger for hypotension removed.
- > Parameters for all age groups.
- > No MER Call for hypertension.

Revised chart Blo	ood Pressure
Blood Pressure	Write ≥110
(mmHg)	100s
Y	90s
	80s
95th Percentile:	70s
Cuff Size:	60s
Use systolic blood	50s
pressure as trigger	40s
for response	Write ≤ 39

MR Form	Previous chart	Revised chart	
	Blood Pressure	Blood Pressure	
MR-59B			
0 - 3 months	Blood Pressure Systolic (mmHg) Diastolic	Blood Pressure	Write ≥110
	(mining) Diastoic	(mmHg)	100s
		Y.	90s
			80s
		95th Percentile:	70s
		Cuff Size:	60s
		Use systolic blood	50s
		pressure as trigger	40s
		for response	Write ≤ 39

MR Form	Previous chart		Revised chart	
	Blood Pressure		Blood Pressure	
	Dioou Flessule			
MR-59C				
3 months –	Blood Pressure	Write ≥ 140	Blood Pressure	Write ≥130
1 year	(mmHg)	130s	(mmHg)	120s
	(11111119)	120s		► 110s
	$\vee$	110s 100s	Y	100s
	Ť	90s		90s
		80s		80s
		70s	95th Percentile: Cuff Size:	- 70s
	Use systolic blood	60s	oun oize.	60s
	pressure as trigger	50s	Use systolic blood	50s
	for response	40s	pressure as trigger for response	40s
		Write ≤ 39	tor response	Write ≤ 39
MR-59D				
				Write ≥140
1 – 4 years	Blood Pressure	Write ≥ 120	Blood Pressure	130s
	(mmHg)	110s	(mmHg)	
		100s	(initing)	► 120s
	Y Y	90s	Y	110s
		80s		► 100s
	$\land$	70s	L L	90s
		60s	95th Percentile:	80s
	Use systolic blood	50s	Cuff Size:	70s
	pressure as trigger	40s		60s
	for response	Write ≤ 39	Use systolic blood	50s
			pressure as trigger	40s
			for response	Write ≤ 39
MR-59E				
5 – 11 years		Write ≥ 140		Write ≥140
-	Blood Pressure	130s	Blood Pressure	130s
	(mmHg)	120s	(mmHg)	120s
		110s	Y	110s
		100s 90s		100s 90s
		80s	A OEth Dessentile:	80s
		70s	95th Percentile: Cuff Size:	70s
	Use systolic blood	60s	lips sustalia bland	60s
	pressure as trigger	50s	Use systolic blood pressure as trigger	50s
	for response	40s	for response	40s
		Write ≤ 39		Write ≤ 39
MR-59F				
12 – 17years		Write ≥ 170		Write ≥150
		160s	Blood Pressure	140s
	Blood Pressure	150s	(mmHg)	130s
	(mmHg)	140s		120s
		130s 120s	Y I	110s
	Y	110s		100s
		100s	05th Porcentile:	90s
		90s	95th Percentile: Cuff Size:	80s
	Use systolic blood	80s		70s
	pressure as trigger	70s	Use systolic blood	60s
	for response	60s 50s	pressure as trigger for response	50s
				Write ≤ 49
			L	

# **Temperature (Degrees Celsius)**

MR Form	Previous chart	Revised chart
	Temperature	Temperature
MR-59B		
0 - 3 months	Write ≥ 39.1 38.6 - 39.0 38.1 - 38.5 37.6 - 38.0 37.1 - 37.5 36.6 - 37.0 36.1 - 36.5 35.6 - 36.0 35.1 - 35.5 Write ≤ 35.0	Write ≥ 39.1 38.6 - 39.0 38.0 - 38.5 37.6 - 37.9 37.1 - 37.5 36.6 - 37.0 36.1 - 36.5 35.6 - 36.0 Write ≤ 35.5
MR-59C	Write ≥ 39.1	Vrite ≥ 39.1
3 months	38.6 - 39.0	38.6 - 39.0
- 1 year	38.1 - 38.5	38.1 - 38.5
	37.6 - 38.0	37.6 - 38.0
MR-59D	37.1 - 37.5	37.0 - 37.5
1 – 4 years	36.6 - 37.0	36.6 - 37.0
	36.1 - 36.5	36.1 - 36.5
MR-59E	35.6 - 36.0 35.1 - 35.5	35.6 - 36.0 35.1 - 35.5
5 – 11 years	Write ≤ 35.0	Write ≤ 35.0
MR-59F		
12 - 17years	Write ≥ 39.1	
(no change)	38.6 - 39.0	
	38.1 - 38.5	
	37.6 - 38.0 37.1 - 37.5	
	36.6 - 37.0	
	36.1 - 36.5	
	35.6 - 36.0	
	35.1 - 35.5	
	Write ≤ 35.0	

## Level of Consciousness – additional to Section C

Previously, all charts combined *Level of Consciousness* and *Sedation Table*, and *Additional Observations* appeared as a separate observation assessment in Section C.

#### Changes:

#### Only one assessment to be used (not both)

- > Level of Consciousness use AVPU scale (Alert, Verbal, Pain, Unresponsive)
  - OR
- > Level of Sedation use for children receiving sedation and/or opioids (don't use AVPU)

MR	Previous chart -	page 3	Revised chart – page 2
Form	Level of Conscio	usness/Sedation	Level of Consciousness (only)
All charts	Level of Consciousness/Sedation           Score         Descriptor           3         Diffuelt to rouse (severe respiratory convession)           2         Easy to rouse, difficulty staying anales           1         Easy to rouse           0         Awake, stert           Additional Observations         Image: Consciousness of the second start of the second steries           Vale patient         1           Pails Score         0           Pails Score         0           Al Rest (2 consciousnes)         0           I Rest (2 consciousnes)         0	Stimulus         Response           Pain, shoulder suprezei, jaw fitnist         Brief eye opening OR any movement OR portegories           Veice, light bouch         Eye opening and eye contact	Alert     Alert     Verbal     (wake patient before scoring)     Duresponsive

## Level of Sedation - Additional to Section C

- > For children receiving sedation and/or opioids only
- Sedation score of 2 is now a red zone trigger MDT review (was RN/RM review) (Refer to Section H: Sedation Score: page 4 to calculate score and document page 3)

MR	Previo	us chart - page 3	Revi	sed chart – page 2		
Form	Level o	f Consciousness/Sedation	Leve	I of Sedation (only)		
All charts	Score 3 Difficul 2 Easy to 1 0 Additional Dt Consciousness 78-edation 78-edational Pain Score A Rest	Sciousness/Seciation       Descriptor     Stimulus     Response       1tb rouse (benere respiratory depression)     Pain, shoulder requests, jaar house, Store afficulty storing analyse     Pain, shoulder requests, jaar house, Notes, jaar house, Store afficulty storing analyse     Pain, shoulder response, ficulty storing store afficulty storing analyse     Pain, shoulder response, Store afficulty storing analyse     Pain, shoulder response, Store afficulty storing analyse     Pain, shoulder response, Store afficulty storing store afficulty store analyse, store afficulty store afficul	N/A tact <10 seconds tact >10 seconds	Level of Sedation For children receiving lation and/or opioids only ke patient before scoring)	3 2 1 0	
		d chart – page 2 f Sedation (only) – Section SE	H: Sedation Score	NSCORE		
	Score	Descriptor	Stimulus Response		Duration	
	3	Difficult to rouse	Pain, shoulder squeeze	Brief eye opening OR any	N/A	
		Difficult to rouse	Pain, shoulder squeeze	movement OR no response	100	
λ	2	Easy to rouse, difficulty staying awake	Voice, light touch		< 10 seconds	
4		Easy to rouse, difficulty staying		Eye opening and eye		
	2	Easy to rouse, difficulty staying awake	Voice, light touch	movement OR no response       Eye opening and eye contact       Eye opening and eye	< 10 seconds	
	2 1 0 Previou Level o	Easy to rouse, difficulty staying awake Easy to rouse	Voice, light touch Voice, light touch N/A	movement OR no response         Eye opening and eye contact         Eye opening and eye contact       N/A         N/A       N/A         Response         Brief eye opening O	< 10 seconds ≥ 10 seconds N/A Duration	
	2 1 0 Previou Level o Score	Easy to rouse, difficulty staying awake Easy to rouse Awake, alert when approached us chart - page 3 f Consciousness/Sedation of Consciousness/Sedation Descriptor Difficult to rouse severe respir	Ation	movement OR no response         Eye opening and eye contact         Eye opening and eye contact         N/A         N/A         Brief eye opening Cany movement OF no response	< 10 seconds ≥ 10 seconds N/A Duration R N/A	
	2 1 0 Previou Level o Score 3	Easy to rouse, difficulty staying awake Easy to rouse Awake, alert when approached us chart - page 3 f Consciousness/Sedation of Consciousness/Sedation Of Consciousness/Sedation Descriptor Difficult to rouse (severe respir depression)	Voice, light touch Voice, light touch N/A attion Stimulus atory Pain, should squeeze faw th	movement OR no response         Eye opening and eye contact         Eye opening and eye contact         N/A         Response         Brief eye opening Cany movement OF no response         Juch       Eye opening and eye contact	< 10 seconds	

## Pain Score – additional to Section C

#### > FLACC table removed

Refer to local guidelines, reference tools - *Acute Pain Management and Opioid Safety in Children (sahealth.sa.gov.au)* - <u>Paediatric Clinical Practice Guidelines | SA Health</u>

#### > Changes to Escalation Response criteria:

- o unrelieved or unexpected pain triggers
- escalation to RN/RM review.

#### > One assessment of pain

• at score of 8-10 > triggers RN/RM review

MR Form	Previous chart - page 3	Revised chart – page 2		
	Pain score	Pain score		
MR-59B 0 - 3 months MR-59C 3 months - 1 year	Pain Score8 -10At Rest5 - 7(2 consecutive)0 - 4	Pain Score8 - 10Refer to FLACC score5 - 70 - 4		
MR-59D 1 – 4 years	Pain Score8 -10At Rest5 - 7(2 consecutive)0 - 4	Pain Score     8 - 10       FLACC     Faces     5 - 7       (Please tick)     0 - 4		
MR-59E 5 – 11 years MR-59F 12 – 17 years	Pain Score8 -10At Rest5 - 7(2 consecutive)0 - 4	Pain Score     8 - 10       PLACC     Faces     Numeric       (Please tick)     0 - 4		

#### Blood Glucose Level (BGL) – additional to Section C

#### All charts

- > needs to be written in mmol/L, in line with date and time
- > no triggers

## Initials - additional to Section C

#### All charts

> space for clinician to record their first and last name initials

## 6. MODIFICATIONS - SECTION D - Page 3

#### All charts

- > Adapted to match the Adult RDR charts.
- > Moved to page 3, opposite the Observation chart.

#### Wording has changed to make clear:

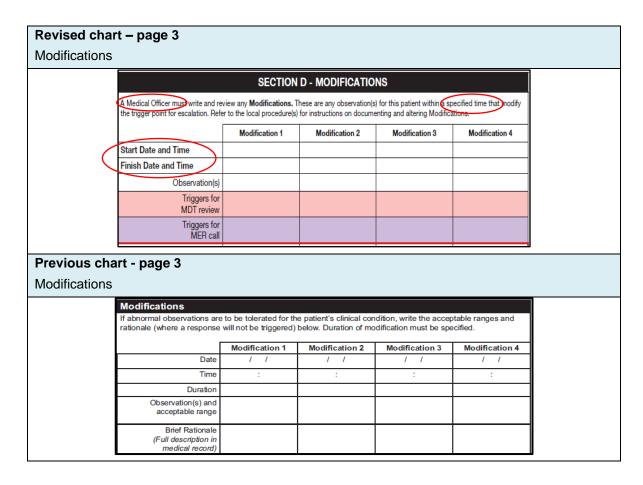
- Modifications are observations for <u>this patient</u> within a <u>specified time</u> that modify the trigger point for escalation.
- > Trigger points are colour coded for MDT review or MER call.

#### Additional space for:

- > Information about triggers for MDT review MER call.
- > <u>Start and finish date and time for a modification.</u>

(The modification stops at the finish time and the observation parameters go back to the pre-set triggers).

- > Colour added to triggers for review.
- > Medical Officer to write and review any modifications.
- > The space for documenting the clinician's name, designation and signature remains the same.



# 7. FREQUENCY OF OBSERVATIONS - SECTION E: Page 3

#### All charts

- > Adapted to match the Adult RDR charts.
- New section to document the ordering of a change in the frequency of observations (observations are at least 4 hourly unless Section E specifies something different).
- > Refer to local procedures (e.g., only a senior RN to change frequency).
- > Increase to minimum of hourly if MDT review.

	SECTION E – FREQUENCY OF OBSERVATIONS						
Observations should be	Observations should be performed routinely at least 4 hourly unless advised below. Refer to local procedure for who can alter frequency.						
Date	(s.g) 06/04/2021	/ /	1 1	/ /	/ /	/ /	/ /
Frequency	2/24						
Name/Designation	Smith RN						

# 8. INTERVENTION OR REVIEW DONE - SECTION F: Page 3 (INCLUDING MDT OR MET CALL)

#### All charts

- > Adapted to match the Adult RDR charts.
- Document the time of intervention as a reference point (in previous chart reference was A, B, C etc.)

SE	SECTION F - INTERVENTION OR REVIEW DONE (INCLUDING MDT OR MET CALL)				
Date	Intervention or review	Patient family/	Physical	Mental	Name
Time	(e.g. Urine Output, increase frequency BGL's, $\mathrm{O_2}$ changes etc)	carer concern	state change	state change	Signature

## 9. RESPONSE CRITERIA AND ACTIONS TO TAKE - SECTION G: Page 4

#### Changes:

- > Wording and formatting changed to align with adult RDR chart
- > Addition of 'Patient or consumer concern' has been added to all three categories of response criteria

#### MER CALL

> Time specified (> 30 mins) for a delayed MDT review - consider MER

#### **MDT Review**

- 0-3 months and 3 months 1 year chart patient has not voided for 8 hours (reduced from 12 hrs)
- > New or increase in Oxygen flow rate
- Minimum hourly observations, as response to MDT review (Escalate if ongoing fluctuations).
- > New or unexplained behavioural change removed moved to RN/RM review criteria

#### **RN/RM** Review

- > New or unexplained behavioural change added moved from MDT review
- > Unrelieved or unexpected pain
- > Escalate to MDT review if not reviewed by RN/RM within 30 minutes
- > Review SpO2 and O2 flow rate requirements

	SECTION G - RESPONSE CRITERIA	AND ACTIONS TO TAKE
	ALWAYS CHECK CURRENT	MODIFICATIONS
	MEDICAL EMERGENCY RESPO	DNSE (MER) CALL
	RITERIA - If one or more observations are in the one or more of the following are occurring;	ACTIONS REQUIRED
<ul> <li>You are worried about the patient</li> <li>A patient or consumer is worried</li> </ul>	Respiratory or cardiac arrest     Threatened alway     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
RESPONSE C	SCIPLINARY TEAM (MDT) REVIEW (Minimum team of RITERIA - If one or more observations are in the red r more of the following are occurring;	registered nurse/midwife and medical practitioner) ACTIONS REQUIRED
<ul> <li>You are worrled about the patient</li> <li>A patient or consumer is worrled</li> </ul>	Poor peripheral circulation     Greater than expected fluid loss     Trine output < <u>Implkg/tir over 4 hours or patient</u> hes not voided for 8 hours     New or increase in 02 flow rate     Escalate to MER cfill 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 <sub>2</sub> and O <sub>2</sub> flow rate requirements
$\underline{}$	/	
	REGISTERED NURSE OR REGISTERED MID	VIFE (and notify Shift Coordinator)
	RITERIA - If one or more observations are in the r one or more of the following are occurring;	ACTIONS REQUIRED
<ul> <li>You are worried about the patient</li> <li>A patient or consumer is worried</li> </ul>	Poor perpheral circulation     New or/unexplained behavioural change     Unreligived or unexpected pain Escalare to MDT review if there are 3 or more observations in yellow zone	Registered nurse/midwlfe review must occur within 30 minutes, or escalate to MDT review     Increase frequency of observations     Manage anxiety, pain and other symptoms     Review SpO <sub>2</sub> and O <sub>2</sub> flow rate requirements

Note: 8 hours for MR-59B and MR-59C only. Others12 hours.

## **10. REFERENCES**

Vital sign trigger changes as per ViCTOR charts (Victorian Paediatric Trigger Charts) based on extensive evidence (see full list of studies <u>here</u>). Predominately <u>Bonafide</u> et al. 2013

## For more information

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