Rapid Detection and Response Paediatric Observation Chart

(3 months - 1 year)
(MR59C)

Hospital: .....

Affix patient identification label in this box

UR Number: .....

Surname: .....

Given name: .....

Second given name: .....

D.O.B: __ __ / __ __ / __ __ __ __ Sex: .....

Chart Number:

General Instructions

Take observations on child (at rest) and record:

- On admission (minimum respiratory rate, oxygen saturation, pulse rate, blood pressure, temperature, level of consciousness/sedation).
- At a frequency appropriate for the patient's clinical state but not less than once/shift for acute inpatients (Blood pressure frequency as per local procedure and increase frequency when clinically indicated).
- Minimum of once daily for patients awaiting discharge placement.

You must record a set of observations including a minimum of respiratory rate, oxygen saturation, pulse rate, blood pressure, temperature, level of consciousness/sedation:

- If the patient is deteriorating or an observation is in a shaded area.
- Whenever you are worried about the patient.

Review is required for unrelieved or unexpected pain that continues to trigger escalation for 2 consecutive values despite medication administration.

When graphing observations, place a dot (•) in the centre of the box which includes the current observation in its range of values and connect it to the previous dot with a straight line. If observations fall above or below graphic parameters, write the value in relevant box.

Whenever an observation falls within a shaded area, you must initiate the actions required for that colour:

- unless a modification has been made.
- unless one or two observations fall into a yellow and/or red zone and;
  - a medical order for a treatment is in place to treat the condition causing the problem and;
  - a registered nurse/midwife or medical doctor determines the medical order for the treatment is clinically indicated and appropriate and can be immediately administered, then,
  - a repeat set of observations is to be taken. If the observation remains in a shaded area, you must initiate action of that coloured zone.

Modifications

If abnormal observations are to be tolerated for the patient's clinical condition, write the acceptable ranges and rationale (where a response will not be triggered) below. Duration of modification must be specified.

	Modification 1	Modification 2	Modification 3	Modification 4
Date	/ /	/ /	/ /	/ /
Time	:	:	:	:
Duration				
Observation(s) and acceptable range				
Brief Rationale *(Full description in medical record)*				
Doctor's Signature				
Doctor's Name *(print)*				
Doctor's Designation				
Midwife/Nurse Signature				
Midwife/Nurse Name *(print)*				
Midwife/Nurse Designation				

RDR Paediatric Observation Chart (3 months - 1 year) MR59C

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Assessment of Respiratory Distress

	Mild	Moderate	Severe
Airway	Secretions cleared by self	Secretions needing suction, partial airway obstruction, stridor	New onset/severe stridor, imminent airway obstruction
Behaviour and feeding	Normal and normal cry	Unsettled, difficulty feeding/sucking, may not tolerate tube feeds	Agitated/confused, drowsy, unable to talk or cry, unable to feed or suck, not tolerating tube feeds
Accessory muscle use	None or minimal	Moderate recession, intermittent tracheal tug	Severe recession, gasping, grunting, extreme pallor, mottled, cyanosis, absent breath sounds, head bob, nasal flaring
Respiratory pattern	Normal/near normal	Abnormal pauses in breathing	Apnoeic episodes
Oxygen (O_2)	No O_2 requirement	Mild hypoxaemia corrected by O_2, increasing O_2 requirements	Hypoxaemia, may not be corrected by O_2, requires more than 60% O_2, CPAP or IPPV

Pain Score - Flacc Pain Scale (Behavioural)

Instructions: 1. Rate patient in each of the five measurement categories 2. Add together 3. Document total pain score

	Score 0	Score 1	Score 2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaints	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or talking, distractible	Difficult to console or comfort

Interventions or Review

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

		Initial *Please print*	Designation
a			
b			
c			
d			
e			
f			
g			
h			

Modifications in use: Yes ☐ No ☐

Date																				
Time																				
Respiratory Rate *(breaths/min)*	Write ≥ 75																			Write ≥ 75
	70 - 74																			70 - 74
	65 - 69																			65 - 69
	60 - 64																			60 - 64
	55 - 59																			55 - 59
	50 - 54																			50 - 54
	45 - 49																			45 - 49
	40 - 44																			40 - 44
	35 - 39																			35 - 39
	30 - 34																			30 - 34
	25 - 29																			25 - 29
	20 - 24																			20 - 24
	15 - 19																			15 - 19
	Write ≤ 14																			Write ≤ 14
Respiratory Distress	Severe																			Severe
	Moderate																			Moderate
	Mild																			Mild
	Nil																			Nil
O_2 Saturation *(%)*	≥ 95																			≥ 95
	92 - 94																			92 - 94
	90 - 91																			90 - 91
	Write ≤ 89																			Write ≤ 89
O_2 Flow Rate *(L/min)*Write value:	> 2 L																			
	≤ 2 L																			
Delivery Method/Air																				
Pulse Rate *(beats/min)*	Write ≥ 180																			Write ≥ 180
	170s																			170s
	160s																			160s
	150s																			150s
	140s																			140s
	130s																			130s
	120s																			120s
	110s																			110s
	100s																			100s
	90s																			90s
	80s																			80s
	70s																			70s
	60s																			60s
	Write ≤ 59																			Write ≤ 59
Capillary Refill *(seconds)*	Write ≥ 2 sec																			Write ≥ 2 sec
	< 2 sec																			< 2 sec
Blood Pressure *(mmHg)*	Write ≥ 140																			Write ≥ 140
	130s																			130s
	120s																			120s
	110s																			110s
	100s																			100s
	90s																			90s
	80s																			80s
	70s																			70s
Use systolic blood pressure as trigger for response	60s																			60s
	50s																			50s
	40s																			40s
	Write ≤ 39																			Write ≤ 39
Temperature *(°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
Weight																				
Intervention	*See chart overleaf*																			*See chart overleaf*

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Medical Emergency Response (MER) Call

Response Criteria
- Respiratory or cardiac arrest
- Threatened airway
- Significant bleeding
- Any observations in a purple zone
- Unexpected or uncontrolled seizure
- Unattended MDT review
- You are worried about the patient

Actions Required ASAP
- Place emergency call and specify location
- Initiate basic/advanced life support
- Notify senior doctor responsible for patient
- Increase frequency of observations post intervention

Multi Disciplinary Team (MDT) Review

(minimum of registered midwife/nurse and medical doctor - check for modifications)

Response Criteria
- Any observations in a red zone
- Poor peripheral circulation
- Greater than expected fluid loss
- New or unexplained behavioural change
- Urine output <1ml/kg/hr over 4 hours or patient has not voided for >12 hours
- You are worried about the patient

Actions Required
- MDT to review patient within 30 minutes (Country Hospitals to refer to local guidelines)
- Increase frequency of observations
- If MDT not attended within 30 minutes escalate to MER

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

RM/RN Review & Notify Shift Coordinator

Response Criteria
- Any observations in a yellow zone
- Poor peripheral circulation
- You are worried about the patient

Actions Required
- Registered midwife/nurse must review the patient
- Increase frequency of observations
- Manage anxiety, pain and review oxygen requirements

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

Level of Consciousness/Sedation

Score	Descriptor	Stimulus	Response	Duration
3	Difficult to rouse (severe respiratory depression)	Pain, shoulder squeeze, jaw thrust	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	N/A	N/A	N/A

Observations Continued

Date																				
Time																				
Level of Consciousness /Sedation Wake patient before scoring	3																			
	2																			
	1																			
	0																			
Pain Score At Rest *(2 consecutive)*	8 -10																			
	5 - 7																			
	0 - 4																			