



Rapid Detection and Response Paediatric Observation Chart
(3 months - 1 year)
MR-59C

Affix patient identification label in this box

U.R. No:.....

Surname:.....

Given Name:.....

Second Given Name:.....

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 SpO₂, blood pressure, pulse rate, temperature, pain score, level of consciousness
- Other observations as indicated including BGL, O₂ Flow rate, O₂ 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 O₂ 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)

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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
<ul style="list-style-type: none"> You are worried about the patient A patient or consumer is worried 	<ul style="list-style-type: none"> Respiratory or cardiac arrest Threatened airway Significant bleeding Unexpected or uncontrolled seizure Consider for delayed MDT review (> 30 minutes) 	<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> You are worried about the patient A patient or consumer is worried 	<ul style="list-style-type: none"> Poor peripheral circulation Greater than expected fluid loss Urine output < 1ml/kg/hr over 4 hours or patient has not voided for 8 hours New or increase in O₂ flow rate Escalate to MER call if there are 3 or more observations in red zone 	<ul style="list-style-type: none"> 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 SpO₂ and O₂ 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
<ul style="list-style-type: none"> You are worried about the patient A patient or consumer is worried 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 SpO₂ and O₂ 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 <i>(breaths/min)</i>	Write ≥ 70										Write ≥ 70	
	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		
Respiratory Distress	Write ≤ 19										Write ≤ 19	
	Severe										Severe	
	Moderate										Moderate	
	Mild										Mild	
O ₂ Saturation (SpO ₂) (%)	Nil										Nil	
	≥ 95										≥ 95	
	92 - 94										92 - 94	
	90 - 91										90 - 91	
O ₂ Flow Rate	Write value (L/min)										Write value (L/min)	
	Write										Write	
Delivery Method	Write										Write	
Probe Change	Tick										Tick	
Pulse Rate <i>(beats/min)</i>	Write ≥ 180										Write ≥ 180	
	170s										170s	
	160s										160s	
	150s										150s	
	140s										140s	
	130s										130s	
	120s										120s	
	110s										110s	
	100s										100s	
	90s										90s	
Capillary Refill	Write ≤ 89										Write ≤ 89	
	Write ≥ 3 sec										Write ≥ 3 sec	
	< 3 sec										< 3 sec	
	Blood Pressure <i>(mmHg)</i>	Write ≥ 130										Write ≥ 130
		120s										120s
		110s										110s
		100s										100s
		90s										90s
		80s										80s
		70s										70s
60s											60s	
50s											50s	
40s											40s	
Temp <i>(°C)</i>	Write ≤ 39										Write ≤ 39	
	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	
	37.0 - 37.5										37.0 - 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	
Level of Consciousness <i>(wake patient before scoring)</i>	Write ≤ 35.0										Write ≤ 35.0	
	Alert										Alert	
	Verbal										Verbal	
	Pain										Pain	
Level of Sedation <i>For children receiving sedation and/or opioids only (wake patient before scoring)</i>	Unresponsive										Unresponsive	
	3										3	
	2										2	
	1										1	
Pain Score <i>Refer to FLACC score</i>	0										0	
	8 - 10										8 - 10	
	5 - 7										5 - 7	
BGL	0 - 4										0 - 4	
	Write (mmol/L)										Write (mmol/L)	
Initials												

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	Given Name:.....	
Second Given Name:.....		D.O.B.:
		Sex/Gender:

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 (<i>print</i>)				
Doctor's Designation				
Nurse/Midwife Signature				
Nurse/Midwife Name (<i>print</i>)				
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	Intervention or review	Patient family/ carer concern	Physical state change	Mental state change	Name
Time	(e.g. Urine Output, increase frequency BGL's, O ₂ changes etc)				Signature
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	