SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
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FUNCTIONAL GROUP(S)	Child and Adolescent Health Clinical Governance
KEY TERMS	Deterioration, paediatric, between the flags, Clinical Emergency Response system (CERS), yellow zone, red zone, blue zone, rapid response, code blue.
SUMMARY	- Between the Flags (BTF) escalation for Paediatric Inpatients, including neonates on paediatric wards. - Operational components of the BTF system including the Paediatric Calling Criteria for initiating a BTF call - District and hospital accountabilities in relation to the BTF system

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Management of the Deteriorating PAEDIATRIC Inpatient

SESLHDPR/284

1. POLICY STATEMENT

Early recognition of the deteriorating child and providing a prompt and appropriate response are essential components of safe quality patient care. For this procedure the term Paediatrics includes patients older than 4 weeks and up to 16 years of age.

SESLHD facilities will utilise a standardised clinical emergency response system (CERS) to facilitate early recognition and respond to paediatric patients with signs of clinical deterioration. The agreed CERS system is the Clinical Excellence Commissions (CEC) Between the Flags program.

This procedure shall be read in conjunction with NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating.

For neonates in special care nurseries, postnatal wards or within the maternity unit refer to SESLHD procedure; SESLHDPR/340 – Management of the Deteriorating NEONATAL inpatient

For pregnant and postnatal women who are less than 20 weeks gestation or more than 6 weeks postnatal refer to SESLHD procedure; SESLHDPR/697 – Management of the Deteriorating ADULT inpatient (excluding maternity).

For pregnant women of 20 weeks gestation and over, and up to 6 weeks postnatal, refer to SESLHDPR/705 - Management of the Deteriorating MATERNITY woman.

For patients over 16 years of age, refer to SESLHDPR/697 - Management of the Deteriorating ADULT inpatient (excluding maternity).

2. BACKGROUND

The Clinical Emergency Response System (CERS) is activated if a child's clinical observations or condition meet calling criteria as listed on the age specific Standard Paediatric Observation Chart (SPOC). CERS aims to identify and reverse early signs of deterioration, through early management and treatment. The success of the system relies on the following:

- Observations monitored at a frequency sufficient to detect deterioration or procedural complications
- Recognition of early signs of deterioration by a staff member
- Activation of the CERS system if observations meet calling criteria or other clinical condition of concern
- Timely medical response and management by a senior member of the primary care team
- Built in escalation to specialised emergency care should the child continue to deteriorate or if the child's condition is life threatening.

This SESLHD procedure will outline specific measures to be implemented across the district to allow a standardised approach to recognising and managing the deteriorating paediatric inpatient.

3. RESPONSIBILITIES

Clinical Nurse/Midwifery Consultant's and Educators will:

- Provide leadership and management in recognising and responding to the deteriorating paediatric patient via the SESLHD Deteriorating Patient Programs (DPP) Committee and Women's & Children's Clinical Stream (WCCS). The SESLHD DPP committee and the WCCS will consist of clinical experts from each local facility
- Provide local guidance and directives on the Clinical Emergency Response System (CERS) to ensure consistency across all local sites
- Provide education guided by the NSW Health Deteriorating Patient Education Strategy.

Medical, Midwifery and Nursing staff will:

- Complete mandatory Maternity and Fetal Safety Education Program and adhere to local guidelines and directives.

Nurse/Maternity Manager's will:

- Support staff education
- Provide guidance on reporting requirements for each facility.

Clinical Governance Units will:

- Communicate with stakeholders, including patients, carers, families, clinicians and the Clinical Excellence Commission, to provide feedback on the performance and effectiveness of the Deteriorating Patient Safety Net System.

4. ASSESSMENT OF DETERIORATION

4.1 Assessment

- A baseline systematic assessment (A-G or agreed equivalent) is to be performed and documented in the paediatric patients' health care record. Assessment needs to include patients and their families/carers in changes to physical and mental state where appropriate.

4.2 Standard clinical tools

- In SESLHD general observations for paediatric patients must be recorded on the NSW Health Standard Paediatric Observation Chart (SPOC)

- There are five age specific standard paediatric general observation charts. Each chart details the yellow zone and red zone calling criteria. The age specific charts are:
  - Under 3 months
  - 3 - 12 months
  - 1 - 4 years
  - 5 to 11 years
  - 12 years and over

- For all other patients, refer to the below SESLHD procedures:
  - SESLHDPR/697 - Management of the deteriorating ADULT inpatient
  - SESLHDPR/705 - Management of the deteriorating MATERNITY woman
  - SESLHDPR/340 - Management of the deteriorating NEONATE inpatient

4.3 Minimum requirement for vital sign monitoring

A full set of vital signs observations must be performed at the time of admission, within one hour of arrival to ward or clinical unit and a full set of vital signs needs to be performed within one hour prior to discharge.

- Frequency of observation are to be attended as per Appendix 2 unless:
  - An individualised monitoring and assessment plan is documented by a Medical Officer (MO) (registrar level or above) in the health care record
- Observations can be increased by both nursing/midwifery and medical staff. Observations frequency is to be increased when:
  - A child's observations fall into the coloured zone of Between the Flags (BTF)
  - The child further deteriorates
  - The child has a CERS call.

4.4 Individualised monitoring and assessment plans

- Paediatric patients who require less frequent monitoring due to clinical situation or diagnosis may have an individualised monitoring and assessment plan as determined by the clinical team and in consultation with the Admitting Medical Officer (AMO). This plan must be documented in the health care record with associated rationale and goals of care.
- All yellow and red zone breaches must be escalated as per local paediatric CERS plan unless an alternative response is documented in the resuscitation plan. Frequency of observations are to be increased following a CERS call and documented in the monitoring and assessment plan.

4.5 Alterations

Altering calling criteria should be undertaken with caution as criteria are sensitive signs of deterioration. Calling criteria should only be altered by the registrar level or above following assessment of the paediatric patient, in consultation with the AMO and must be formally reviewed by the AMO. When altering calling criteria, a

rationale must be documented in the health care record. This must include a minimum timeframe for review.

4.5.1 Chronic

For patients known to have chronically abnormal vital signs (considered usual for the patient) consider whether clinical review or rapid response criteria require alteration. If required, complete the alterations to calling criteria section on the standard paediatric observation chart. Any alteration to yellow zone or red zone criteria must have a clinical rationale documented in the medical record. Alterations for chronic conditions should be reviewed within 48 hours.
NOTE: The AMO must authorise any criteria modification.

4.5.2 Acute

Acute alterations should be reviewed by the admitting team within eight hours or sooner if clinical condition requires. Acute alterations are not to be used for extended periods of time. Regular clinical review of the paediatric patient is required. The next review due date and time should be documented on the standard paediatric observation chart.

4.6 Palliative care and last days of life

- All palliative or end of life paediatric patients are to have an individualised monitoring and assessment plan documented in the health care record that aligns with their goals of care
- This is to include the use of the not for Rapid Response (NRR) function on the BTF observation chart and the ceiling of care documented on the Resuscitation plan.
- Ensure paediatric patients and their families/carers are consulted when determining the appropriate plan
- An end of life care plan is initiated.

4.7 Cultural support

- Aboriginal and Torres Strait Islander patients and their families may require additional supports sometimes as an inpatient. This can include extended family, Aboriginal health professionals such as Aboriginal liaison officers, health workers or culturally specific services
- Support for non- English speaking culturally and linguistically diverse (CALD) families is available through cross cultural workers (weekdays, business hours) and the interpreter service.
  NSW Ministry of Health Policy Directive PD2017_044 – Interpreters – Standard Procedures for Working with Health Care Interpreters.

5. CLINICAL EMERGENCY RESPONSE SYSTEMS (CERS)

- All facilities that admit paediatric patients must have a paediatric CERS plan in place. The agreed CERS program for SESLHD is BTF.

- All facilities are to have paediatric CERS protocols in place in accordance with the principles outlined in NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating and address the following:
  - Clearly outline paediatric CERS team members and responsibilities
  - All facilities are to use the Clinical Review, Rapid Response and Code Blue process. All calls are to be put through 2222
  - All facilities that admit paediatric patients are to have an agreed set of emergency equipment based upon best practice guidelines
  - The agreed patient carers and family escalation process in SESLHD is the CEC's REACH program. Clearly outline the escalation model available for parents and carers of paediatrics which enables them to directly escalate to a clinician, if they have any clinical concerns on deterioration.

5.1 CERS in specialty areas

- All speciality areas that require a paediatric CERS response must have localised protocols in place to manage the response
- Any specialty area that is exempt from paediatric CERS must be defined in the local paediatric CERS protocols.

5.2 Blue Zone

- Each facility must have a local protocol guidance for management of the paediatric patient in the blue zone according to the principles outlined in NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating and address the following:
  - Increased frequency of observation as clinically indicated
  - Escalation process
  - Documentation requirements.

5.3 Yellow Zone/Clinical review

- Each facility must have local protocol in place for the paediatric patient clinical review process according to the principles outlined in NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating and address the following:
  - 2222
  - Additional calling criteria (eg fluid balance)
  - Clinical review to be documented on the yellow zone form in eMR
  - Increased frequency of observations/review as clinically indicated.

5.4 Rapid response process

- Each facility must have local protocol in place for the paediatric patient rapid response process according to the principles outlined in NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating and address the following:
  - 2222
  - Additional calling criteria (eg fluid balance)

- Rapid response to be documented on the red zone form in eMR
- Increased frequency of observations to hourly or more frequently if clinically indicated

5.5 Code Blue process

- Code Blue is a medical emergency with loss of airway, breathing, circulation or disability (A,B,C,D)
- Each facility must have local protocol in place for the paediatric patient's code blue process according to the principles outlined in NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating and address the following:
  - 2222
  - Additional calling criteria (eg fluid balance)
  - Contemporaneous documentation is to be entered onto the Paediatric Resuscitation Form during the Code Blue, along with completion of the Red Zone form in eMR
  - Increased frequency of observations to hourly or more frequently if clinically indicated.

5.6 Patient transfer processes

- Yellow zone: Patients with observation in the yellow zone can be transferred between clinical areas provided there is a clinical plan in place
- Red zone: Each facility must have local process in place for the intra-hospital transfer of patients in the red zone.

5.7 Paediatric escalation beyond the facility and transfer process

For all paediatric patients who are clinically unstable or deteriorating (or for whom there is a high level of clinical concern), medical or nursing staff need to urgently contact the clinical support or on-call paediatrician (for SSEH this will be a call to SCH – Randwick on-call paediatric registrar) to discuss the patient's ongoing care and transfer.

This escalation of care is necessary to review what stabilisation or resuscitation the patient may require as well as the end point for NETS (Newborn and Paediatric Emergency Transport Service) transfer to tertiary paediatric services which can then inform the documented treatment plan.

For inter-faculty transfer please refer to NSW Ministry of Health Policy Directive PD2010_031 - Children and Adolescents - Inter-Facility Transfers.

6. EDUCATION

- Education will be provided as per the CEC Deteriorating Patient Education Strategy.

7. REFERENCES

- NSW Ministry of Health Policy Directive PD2022_028 - Aboriginal Cultural Training, Respecting the Difference
- NSW Ministry of Health Policy Directive PD2010_031 - Children and Adolescents – Inter-Facility Transfers
- NSW Ministry of Health Policy Directive PD2017_044 – Interpreters – Standards Procedures for Working with Health Care Interpreters
- NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are Deteriorating

8. APPENDICES:

1. Key Terms
2. Minimum number and frequency for vital sign observations

9. VERSION AND APPROVAL HISTORY

Date	Version No.	Version and approval notes
July 2013	1	Adapted by Suzanne Schacht from old Area Policy PD 208; Paediatric PACE procedure developed as a separate procedure. Updated to include Monitoring of Observations; PACE criteria and procedure mapped to align with the BTF observation charts Revised by Scarlett Acevedo, District Policy Officer.
November 2013	2	Revised by Suzanne Schacht following consultation period. Re-formatted by Scarlett Acevedo, District Policy Officer
September 2014	2	Statement added relevant to non-tertiary paediatric facilities *6.3 - PAEDIATRIC ESCALATION BEYOND THE FACILITY AND TRANSFER PROCESS* Endorsed and approved by the relevant divisions, streams and committees (Women's & Children's stream, local sector as well as local and LHD deteriorating patient and CERS committees).
October 2015	3	Reviewed by Clinical Streams. Endorsed by Executive Sponsor
November 2015	3	Endorsed by SESLHD Clinical and Quality Council
June/September 2018	4	Minor review to include increasing clarity re role of medical responders and inclusion of a Paediatric Education Matrix as an appendix. Draft for Comment period for feedback. Final draft approved by Executive Sponsor.
November 2018	5	Minor review to Matrix – Appendix 1. Processed by Executive Services prior to publishing.
March 2021	6	Major review commenced. Rebecca Hughes Deteriorating Patient CNC, Alison Brown CMC WCCS, Pauline Best Paediatric Nurse Educator SGH, Julie Friendship CNC Paediatric SESLHD, Olivia Taripo A/NUM TSH, Catharine Dias, Education TSH
April 2021	6	Draft for comment period.
June 2021	6	Feedback incorporated. Final version approved by Executive Sponsor. To be tabled at June 2021 Clinical and Quality Council for

		approval.
June 2021	6	Endorsed by SESLHD Clinical and Quality Council
27 July 2023	6.1	Minor review by Rebecca Hughes SESLHD CERS CNC, Natalie Darlington, SESLHD Paediatric CNC, Rebecca Kelly CME TSH, Women's and Children's stream. Cultural support and education sections updated.

Appendix 1 – KEY TERMS

Key terms as defined by NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating

2 KEY TERMS

Acute alterations to calling criteria	Alterations made to calling criteria for a condition where the patient's observations will fall outside the standard parameters for a defined period of time, while treatment is taking effect. Acute alterations to calling criteria are set for a defined period of time (not longer than 8 hours), after which they revert back to standard calling criteria. Patients with acute alterations to calling criteria must have daily medical reviews to ensure their clinical progress aligns with the patient's treatment plan.
Additional criteria	Signs or symptoms of deterioration depicted on the standard observation chart that a patient may exhibit outside of, or in addition to, the standard calling criteria for vital sign observations.
Agreed signs of deterioration	Signs or symptoms of deterioration that a patient may exhibit outside of, or in addition to, the standard calling criteria and additional criteria that are agreed following engagement of the patient, carer and family, and tailored to the patient's specific circumstances.
Altered calling criteria	Changes made to the standard calling criteria by the AMO/delegated clinician responsible, to take account of a patient's unique physiological circumstances and/or medical condition. Alterations may be 'acute' or 'chronic'.
A-G systematic Assessment	A structured approach to physical assessment that considers a patient's **A**irway, **B**reathing, **C**irculation, **D**isability, **E**xposure, **F**luids, **G**lucose.
Attending Medical Officer (AMO) / Delegated clinician responsible	Senior medical practitioner who has primary or delegated responsibility and accountability for a patient on a temporary or permanent basis. For an inpatient, this is the named Attending Medical Officer (AMO) or another consultant, staff specialist or visiting medical officer with delegated responsibility. As defined in local guidelines and following a risk assessment, the delegated clinician responsible may also be a senior clinician such as a nurse practitioner. In the non-hospital/residential setting this may be the patient's general practitioner.
Balancing measure/s	A unit of data that measures whether changes to one part of a system have an impact on another part of the system and the size of the effect.
Behaviour change	Changes to the way a patient interacts with other people or their environment that deviate from their baseline or their expected response, based on developmental age. Changes may present as shifts in cognitive function, activity/tone, perception, or emotional state, such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.

Blue zone	A coloured zone on the standard clinical tools that requires an increase in the frequency of observation. Staff are to consider calling for an early clinical review.
Clinical Emergency Response System (CERS)	A formalised system for staff, patients, carers and families to obtain timely clinical assistance when a patient deteriorates (physiological and/or mental state). The CERS includes the facility-based and specialty unit based responses (clinical review and rapid response), as well as the formalised referral and escalation steps to seek expert clinical assistance and/or request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility).
CERS Assist	A NSW Ambulance program whereby urgent additional clinical assistance is provided in response to a rapidly deteriorating patient (red zone observations or additional criteria) in a public health care facility.
Chronic alteration to calling criteria	Alterations to calling criteria where a patient has a chronic (lasting >3 months) health condition which causes their normal observations to fall outside standard parameters. Chronic alterations are set for the duration of the patient's episode of care and are reviewed during routine medical review and assessment of the patient.
Clinical Review	A review of a deteriorating patient undertaken within 30 minutes by the clinical team responsible for the patient's care, or designated responder/s, as per the local CERS protocol.
Clinical team responsible for the patient's care	The clinicians, led by the AMO/delegated clinician responsible, who are involved in, and responsible for, the care of the patient on a temporary or permanent basis. In most cases this is the medical team unless otherwise specified.
Clinical service	A health professional or group of professionals who work in co-operation and share common facilities or resources to provide services to patients for the assessment, diagnosis and treatment of a specific set of health-related problems/conditions in a facility or in the community.
Clinical unit	A subset of a facility or service with a special clinical function.
Clinician/s	Medical, nursing, midwifery and allied health professionals who provide direct patient care.
Deterioration in mental state	A negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.[7]

Deteriorating Patient Safety Net System	The NSW Health Deteriorating Patient Safety Net System refers collectively to the various individual programs and frameworks implemented by NSW Health facilities/clinical services or clinical units to support the recognition and appropriate management of patients who deteriorate.
End of life	Refers to the timeframe an individual is clearly approaching the end of their life and is living with and/or impaired by a life-limiting illness. This includes the patient's last weeks or days of life, when deterioration is irreversible and when a patient is likely to die in the next 12 months[10].
Facility	A building or structure where healthcare is provided by a public health organisation, such as a hospital, multi-purpose centre or office-based clinic.
Family of measures	A collection of outcome, process and balancing measures that monitor many facets of the system and provides a framework to understand the impact of changes.
Individualised monitoring and assessment plan	A plan for assessing and monitoring the patient's clinical situation that considers their diagnosis, clinical risks, goals of care and proposed treatment, and specifies the vital signs and other relevant physiological and behavioural observations to be monitored and the frequency of monitoring[7, 8].
ISBAR	An acronym for **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, a structured communication tool.
Last days of life	Refers to the last 24-72 hours of life when treatment to cure or control the person's disease has stopped and the focus is on physical and emotional comfort and social and spiritual support.
New onset confusion	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days)[11].
Outcome measure/s	A unit of data that measures whether changes to the system have an impact on the intended recipient and the size of the effect.
Palliative care	An approach that aims to prevent and relieve suffering and improve the quality of life of patients and their families who are facing the problems associated with life-threatening illness through early identification and assessment and treatment of pain and other physical, psychosocial and spiritual issues[10].
Process measure/s	A unit of data that measures whether the system is performing as it is intended to and that activities are occurring as planned, and the extent to which that is happening.

Public health organisation (PHO)	Local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.
Rapid response	An urgent review of a deteriorating patient by a rapid response team (RRT), or designated responder/s, as defined in the local CERS protocol.
R.E.A.C.H	An acronym for **R**ecognise, **E**ngage, **A**ct, **C**all, **H**elp is on its way. R.E.A.C.H is a CEC program for patients, carers and families to directly escalate concerns about deterioration through the local CERS.
Red zone	Coloured zone on the standard clinical tools that represent warning signs of deterioration for which a rapid response call (as defined by the local CERS protocol) is required.
Resuscitation Plans	A medically authorised order to use or withhold resuscitation measures (formerly called 'No CPR Orders'). Resuscitation Plans can also be used to document other time-critical clinical decisions related to end of life. A Resuscitation Plan is made: • With reference to pre-planning by patients (such as Advance Care Directives or plans) • In consultation with patients, carers and families • Taking account of the patient's current clinical status, as well as their wishes and goals of care. Resuscitation Plans are intended for use for patients 29 days and older in all NSW PHOs, including acute facilities; sub-acute facilities; ambulatory and community settings; and by NSW Ambulance [12].
Special Care Nursery	A clinical unit with space designated for the care of neonates who require additional support, or who need additional monitoring and/or observation[13,18].
Standard calling criteria	Signs and symptoms that a patient is deteriorating and may require review of their monitoring plan or escalation of care through the Clinical Emergency Response System to appropriately manage the deterioration. Standard calling criteria are depicted on standard observation charts as blue, yellow and red zones.
Standard clinical tools	A tool or resource that supports clinicians to recognise when a patient is deteriorating and outlines the appropriate response, such as the sepsis pathways; electronic fetal heart rate monitoring algorithm and labels; Comfort Observation and Symptom Assessment chart; and Resuscitation Plan. as well as the NSW Health standard observation charts.

Standard observation chart	Standardised observation chart approved for use by the NSW Ministry of Health. These have been developed for a variety of clinical settings.
Track and trigger tool	A tool, such as the standard observation chart, that records vital sign observations and allows them to be tracked over time to support identification of a change in the patient's condition that requires a review and/or change in management or frequency of observation.
Transfer of care	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. Also known as clinical handover.
Yellow zone	Coloured zone on the standard observation charts and standard clinical tools that represent warning signs of deterioration for which a clinical review or other CERS call may be required.

Appendix 2 – Minimum number and frequency for vital sign observations

A full set of vital signs observations must be performed at the time of admission, within one hour of arrival to ward or clinical unit and a full set of vital signs needs to be performed within one hour prior to discharge

Table 2 NSW Ministry of Health Policy Directive PD2020_018 - Recognition and management of patients who are deteriorating

Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Adult inpatients	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Including pregnant women greater than twenty (20) weeks gestation and less than six (6) week post-partum admitted for a condition unrelated to pregnancy who are monitored on the Standard Maternity Observation Chart (SMOC).
Mental health acute and subacute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then daily thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Mental state assessment of patients within a mental health inpatient unit are to be completed in line with Engagement and Observation in Mental Health Inpatient Units PD2017_025.
Mental health non-acute	Three (3) times per day at eight (8) hourly intervals for a minimum of 48 hours. Then monthly thereafter.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, pain score	Patients with active comorbid physical health conditions or aged 65 years and over are to have observations no less than weekly and are to have a comprehensive systematic physical assessment completed at least monthly.
Hospital in the Home	At least once during each consultation/visit (17)	To be determined locally based on the models of care and assessment of risk	
Special Care Nursery	Six (6) times per day at four (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, behaviour change*, pain score	

Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Newborn	**Before leaving the birthing environment** One (1) full set of vital signs observations and a newborn risk assessment completed If perinatal risk factors are identified and/or observations within the blue, yellow or red zone and/or additional criteria present, further observations must be recorded on a Standard Newborn Observation Chart (SNOC) six (6) times per day at four (4) hourly intervals.	Respiratory rate, oxygen saturations, heart rate and temperature	Newborns with low or no identifiable risk factors are to be monitored/assessed in-line with local protocols.
Paediatric inpatients	Six (6) times per day at four (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	Baseline blood pressure (BP) is required within 24 hours of admission. Additional BPs are to be taken as clinically indicated (PD2010_32)
Maternity/ antenatal inpatient	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*. For fetal heart rate monitoring requirements refer to Maternity – Fetal heart rate monitoring GL2018_025	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Maternity/ postnatal inpatient with no identified risk factors	**Before leaving the birth environment** One (1) full set of vital signs observations and a maternity risk assessment completed.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	If a woman has observations in a coloured zone or identified risk factors, vital sign observations are to be performed four times per day at six hourly intervals. Women receiving midwifery care in the home are to be monitored according to local protocol, refer to section 4.6.

Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
Maternity/ postnatal inpatient with risk factors	Four (4) times per day at six (6) hourly intervals.	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
Inpatient sub-acute/ long stay/ rehabilitation	Twice a day at a maximum interval of 12 hours apart	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops an acute medical/ physiological problem the required frequency of observations reverts to a minimum of four (4) times per day at six (6) hourly intervals
Inpatient palliative care	Twice a day at a maximum interval of 12 hours apart	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	If a patient develops acute medical/physiological problems are managed in line with their goals of care and Resuscitation Plan
Residents in long term care facilities, such as a multipurpose service (MPS)	At least once per month	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, pain score	The frequency of observations may change depending on the resident's condition and will be determined locally by the AMO/delegated clinician responsible for the resident's care. Additional vital signs may be determined as clinically appropriate for the patient cohort cared for in these settings, such as weight, and monitored on a regular basis.

* Includes an assessment of the patient's behaviour in the context of their developmental age and/or baseline assessment, noting changes in their cognitive function, activity/tone, perception, or emotional state such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.