NSW GOVERNMENT Health

STANDARD NEWBORN OBSERVATION CHART

POSTNATAL/SPECIAL CARE NURSERY

☐ Altered Calling Criteria

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	

ALL OBSERVATIONS MUST BE GRAPHED — COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Time of birth				
	Date			Date
	Time			Time
		1st Set	Continue if Newborn has any Blue, Yellow or Red Zone observations or additional criteria and/or any Newborn Risk factors	

AIRWAY / BREATHING

Respiratory Rate ● (breaths per minute): 90, 85, 80, 75, 70, 65, 60, 55, 50, 45, 40, 35, 30, 25, 20

Resp Distress: Yes / No

SpO_2 ●: 100, 95, 90, 85, <80, Probe Change

Oxygen: L/min or %, Pressure/flow, Device / mode

CIRCULATION

Heart Rate ● (Apical) (beats per minute): 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

Capillary Refill: ≥3 Seconds / <3 Seconds

Blood Pressure (mmHg): Systolic, Diastolic, Mean

PAIN

Moderate to Severe > 7 / Minimal / No Pain ≤ 7

SCORING SCALE BASED ON THE PREMATURE INFANT PAIN PROFILE – REVISED (PIPP-R)

Initials

☐ Increase Frequency of Observations ☐ Clinical Review ☐ Rapid Response

NSW GOVERNMENT Health

STANDARD NEWBORN OBSERVATION CHART

POSTNATAL/SPECIAL CARE NURSERY

☐ Altered Calling Criteria

FAMILY NAME | MRN | GIVEN NAME | ☐ MALE ☐ FEMALE | D.O.B. _____ / _____ / _____ | M.O. | ADDRESS | LOCATION

ALL OBSERVATIONS MUST BE GRAPHED — COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Time of birth | Date | Time | 1st Set | Continue if Newborn has any Blue, Yellow or Red Zone observations or additional criteria and/or any Newborn Risk factors

EXPOSURE

Temperature (°C) ● (Check unit policy): 40, 39.5, 39, 38.5, 38, 37.5, 37, 36.5, 36, 35.5, 35, 34.5, 34

Crib temp(°C): Temperature / Type of crib

O=Open H=Humidicrib

Jaundice: < 24 hours after birth / ≥ 24 hours after birth

Scalp Check

Prevention Detection and Management of Subgaleal Haemorrhage in the Newborn – *RANZCOG statement C-Obs 28*

Inspect and palpate the scalp at 1, 2, 4, 6, 8 and 12hrs and record findings

Inspect scalp for bruising, abrasions and cephalohaematoma *(Note: cephalohaematoma doesn't cross skull suture lines)*

Palpate for free moving fluid under the scalp *(Note: crosses suture lines)*, oedema or ballotable / boggy consistency of scalp

Observe for elevation & displacement of the earlobes, peri-orbital oedema, and pain on handling.

Inspection	**N** = Normal	**Br** = Bruising	**A** = Abrasion	**CS** = Caput Succedaneum	**C** = Cephalohaematoma
Palpation	**N** = Normal	**B** = Ballotable boggy mass/Subgaleal haemorrhage			

Blood Glucose Level: > 10 mmol/L / 2.6-10 mmol/L / 1.7-2.5 mmol/L / < 1.7 mmol/L

Initials

NEWBORN RISK ASSESSMENT

If the newborn has any of the following signs of deterioration or risk factors identified escalate as per your local CERS

Does the newborn have any of the following signs of deterioration? (circle all appropriate)

Grunting	Chest recession	Lethargy	Poor feeding	Jitteriness	Temperature instability
Nasal flaring	Cyanosis	Pallor	Irritability	Seizures	Abnormal movements

Is the newborn at risk of any of the following? (tick all appropriate)

Respiratory distress	☐ Cord pH <7.1/Lactate >6mmol/L or Apgar <7 @ 5 minutes ☐ Caesarean section <39 weeks	☐ Meconium stained liquor ☐ Resuscitation > 10 minutes
Sepsis	☐ Maternal prolonged rupture of membranes > 18 hrs ☐ Maternal GBS	☐ Maternal pyrexia/infection
Jaundice	☐ Blood group incompatibility or known maternal antibodies ☐ Family history of G6PD or severe jaundice in the newborn	☐ Preterm < 37 weeks ☐ Severe bruising
Hypoglycaemia	☐ Maternal history of Type 1 or gestational diabetes ☐ Growth restriction (< 2.5kg at 37-38 weeks or < 2.7kg at 39 weeks)	☐ Birth weight > 4.5kg ☐ Infant < 37 weeks with no other risk factors
Subgaleal Haemorrhage	☐ Vacuum/forceps/unsuccessful instrumental birth – **DO NOT USE A BONNET**	
Maternal Opiates	☐ <4 hours prior to birth - *observations recorded every 15 minutes for the first hour, then at intervals determined by the condition of the newborn for at least 4 hours after birth.*	

Name (BLOCK letters): _____ **Designation:** _____

Signature: _____ **Date:** _____ **Time:** _____

DO NOT PRINT

SMR110014

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH606540 041016

NSW GOVERNMENT | Health

STANDARD NEWBORN OBSERVATION CHART

POSTNATAL/SPECIAL CARE NURSERY

☐ Altered Calling Criteria

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	

ALL OBSERVATIONS MUST BE GRAPHED — COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Gestational Age (weeks)	Birth Weight (kg)	Centile

OTHER CHARTS IN USE

- ☐ **Fluid Balance**
- ☐ **Neonatal abstinence screening**
- ☐ **Clinical Pathway**
- ☐ **Apnoea chart**
- ☐ **Feeding chart**
- ☐ **Centile / growth chart**
- ☐ **Bilirubin / Jaundice**
- ☐ **Other** _____
- ☐ **Other** _____

NEWBORN RISK FACTORS
Is the newborn at risk of clinical deterioration?

All newborns must have a set of observations (respiratory rate, heart rate and temperature) documented and a 'Newborn Risk Assessment' (see page 3) completed before discharge from the "birthing environment".

Continue recording all observations on the Standard Newborn Observation Chart (SNOC) if the Newborn has any Blue, Yellow or Red Zone observations or additional criteria and/or any Newborn risk factors.

If a clinically significant event occurs escalate care of the Newborn in accordance with local Clinical Emergency Response System (CERS) protocols and restart observations on the SNOC.

PRESCRIBED FREQUENCY OF OBSERVATIONS

In the absence of a clinical pathway observations must be performed routinely at least 4th hourly for at risk newborns, unless advised below

DATE:	dd/MM/yy				
TIME:	hh:mm				
Frequency Required	Twice daily				
Name (BLOCK letters)	P. SMITH				
Signature	P. SMITH				
Designation	Midwife				
Attending Medical Officer Signature	R. Bloggs				

ALTERATIONS TO CALLING CRITERIA
MUST BE REVIEWED WITHIN 24 HOURS OR EARLIER IF CLINICALLY INDICATED
Any alterations MUST be signed by a Medical Officer and confirmed by the Attending Medical Officer
Document rationale for altering CALLING CRITERIA in the newborn's health care record

DATE:	dd/MM/yy				
TIME:	hh:mm				
Next review due Date & Time	dd/MM/yy hh:mm				
Yellow Zone	XX – XX				
Red Zone	≤ or ≥XX				
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.			
5.			

EXAMPLE

STANDARD NEWBORN OBSERVATION CHART

SMR110.014

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR THE NEWBORN

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF THE NEWBORN

Blue Zone Response

IF THE NEWBORN HAS ANY BLUE ZONE OBSERVATIONS YOU MUST

1. Initiate appropriate clinical care
2. Increase the frequency of observations as indicated by the newborn's condition
3. Fully review the newborn in consultation with the **MIDWIFE / NURSE IN CHARGE**

You can make a call to escalate the care of the newborn at any time if worried or unsure whether to call

Consider the following

- What is usual for the newborn and are there are any documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the abnormal observation reflect deterioration in the newborn?
- Is there an adverse trend in observations?

Yellow Zone Response

IF THE NEWBORN 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 the newborn's condition.
3. Consult promptly with the **MIDWIFE / NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following

- 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 the newborn?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess the newborn 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 the newborn'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 requirements
- Systolic blood pressure 90 – 100 or 40 – 60 mmHg
- Weight loss > 10%
- Irritability, poor handling, excessive sleeping, poor feeding
- Jaundice at greater than 14 days following birth
- Temperature instability
- Failure to pass meconium within 48 hours
- Failure to pass urine within 24 hours
- **Concern by you or any staff or family member**

CONSIDER IF THE NEWBORN'S DETERIORATION COULD BE DUE TO SEPSIS, CONGENITAL HEART DISEASE, HYPOVOLAEMIA OR METABOLIC DISEASE

Red Zone Response

IF THE NEWBORN 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 **MIDWIFE / NURSE IN CHARGE** that you have called for a Rapid Response
3. Repeat and increase the frequency of observations as indicated by the newborn's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in the newborn'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**
- **Newborn unresponsive**
- Deterioration not reversed within 1 hour of Clinical Review
- Apnoea
- Clinical suspicion of sepsis
- 3 or more simultaneous 'Yellow Zone' observations
- Systolic blood pressure >100 or <40mmHg
- Significant bleeding
- New or prolonged seizure activity
- **Serious concern by you or any staff or family member**

SIDO NOT PRINT

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

SMR110014