

# SESLHD PROCEDURE COVER SHEET



**Health**  
South Eastern Sydney  
Local Health District

<b>NAME OF DOCUMENT</b>	Management of the Deteriorating NEONATAL inpatient
<b>TYPE OF DOCUMENT</b>	Procedure
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<b>EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR</b>	Director Clinical Governance and Medical Services
<b>AUTHOR</b>	Rebecca Hughes CNC Deteriorating Patient Programs SGH Alison Brown CMC Women's and Children's Clinical Stream SESLHD on behalf of the Deteriorating Neonate working party <a href="mailto:Alison.Brown3@health.nsw.gov.au">Alison.Brown3@health.nsw.gov.au</a>
<b>POSITION RESPONSIBLE FOR THE DOCUMENT</b>	CMC Women's and Children's Clinical Stream SESLHD
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<b>KEY TERMS</b>	Deteriorating neonate/newborn/neonatal, Special Care Nursery (SCN), Neonatal intensive care unit (NICU), Newborn Care Centre Clinical Emergency Response (CERS) protocols, Standard Newborn Observation Chart (SNOC), Between the Flags (BTF),
<b>SUMMARY</b>	Between the Flags (BTF) escalation Neonates/Newborns in; Birthing, Theatre, Emergency, Nurseries, Postnatal wards. <u>This is not guidance for neonates in paediatric wards.</u> It provides CERS neonatal guidance including: -Operational components of the BTF system & the Neonatal Calling Criteria -District & hospital accountabilities in relation to the BTF system

## **COMPLIANCE WITH THIS DOCUMENT IS MANDATORY**

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## 1. POLICY STATEMENT

Early recognition of the deteriorating neonate and providing a prompt and appropriate response are essential components of safe quality patient care.

SESLHD facilities will utilise a standardised clinical emergency response system (CERS) to facilitate early recognition and respond to neonates with signs of clinical deterioration. The agreed CERS system is the Clinical Excellence Commissions (CEC) Between the Flags (BTF) 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 paediatric patients including neonates on paediatric wards refer to SESLHD Procedure [SESLHDPR/284 - Management of the Deteriorating PAEDIATRIC Inpatient.](#)

For pregnant and postnatal women who are less than 20 weeks gestation or more than 6 weeks postnatal refer to the [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.

[NSW Health Maternity Fetal Heart Rate Monitoring Guideline GL2018\\_025](#)

## 2. BACKGROUND

This SESLHD procedure will outline specific measures to be implemented across the district to allow a standardised approach to recognising and managing the deteriorating neonatal inpatient in birthing services, nurseries and postnatal wards. This is not guidance for neonates on paediatric wards.

## 3. GOVERNANCE

SESLHD will:

- Provide leadership and management of recognising and responding to the deteriorating neonatal patient via the SESLHD Deteriorating Patient Programs (DPP) Committee and the Woman's and Children's Clinical Stream (Neonatal, Child and adolescent stream). The SESLHD DPP committee and Woman's and Children's Clinical Stream (Neonatal, Child and adolescent stream) 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 occurs

- Provide education guided by the NSW Health Deteriorating Patient Education Strategy
- Provide guidance on reporting requirements for each facility
- 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 Baseline Assessment comprises:

- For newborns: Apgar scores at time of birth. Vital signs and A-G or equivalent, assessment prior to transfer to ward.
- SCN/postnatal admissions: systematic examination performed (e.g. A-G or equivalent), including clinical parameters and vital signs. These are documented in the neonatal patients' health care record together with concerns expressed by parents and carers

##### 4.2 Standard clinical tools

- In SESLHD the NSW Health Standard Newborn Observation Chart (SNOC) is used to record observations for neonatal patients on postnatal wards
- If the neonate requires a higher level of care like Special Care Nursery (SCN) or Neonatal Intensive Care Unit (NICU), state/district approved Newborn Care Centre (NCC) observation charts are used according to the neonate's condition

##### 4.3 Minimum requirement for vital sign monitoring:

***All facilities are to have local guidelines on vital sign monitoring and escalation processes***

- Frequency of observations 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 Neonates observations fall into the coloured zone of Between the Flags (BTF) observation chart
  - The neonate further deteriorates
  - The neonate has a CERS call
- All newborns must have a complete set of vital signs including oxygen saturations documented either prior to discharge from the birthing environment and/or on postnatal ward; depending on local practice
- In addition, 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
- A full set of observations are to be attended within one hour prior to discharge
- Newborns with low or no identifiable risk factors are to be monitored / assessed in line with local/ facility protocols
- Newborns with identifiable perinatal risk factors at birth are to be monitored/ assessed in line with local/facility protocols. For example, observe the neonate for signs and symptoms of withdrawal, if there has been maternal use of Selective Serotonin Reuptake Inhibitor (SSRI)

- If the use of maternal opioid therapy in labour occurs, observations should continue to be recorded every 15 minutes for the first hour, then hourly for the next four hours at a minimum after birth. If maternal opioid use has consistently occurred in pregnancy, signs and symptoms of Neonatal Abstinence Syndrome (NAS) are to be observed and managed according to protocol
- Extra surveillance is required for neonates when maternal pregnancy care has been
  - sporadic
  - non-existent
  - has a High Risk Birth Alert (HRBA)
  - is under the guidance of Department of Community Justice (DCJ)

Not complying with instructions from HRBA and DCJ in a timely manner, may result in deterioration due to maternal factors influencing a neonates deterioration, which may result in an assumption of care.

**4.4 Individualised monitoring and assessment plans**

- Neonates who require **less** frequent monitoring due to clinical situation or diagnosis must have an individualised monitoring and assessment plan as determined by the clinical team 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 CERS 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**

- Standard calling criteria may be altered by a MO (registrar level or above) following assessment of the newborn only in consultation with the AMO / delegated clinician responsible. When altering calling criteria, a rationale must be documented in the health care record. This must include a minimum timeframe for review and vital sign observation.

**4.5.1 Chronic**

- Chronic alterations may be set to align with neonate altered baseline, and can be set for the duration of the neonates episode of care
- If the neonate has a calling criteria altered 'chronically' (e.g. palliative care patients), they will still need a documented medical review on a daily basis, to avoid oversight of treatable medical complications.

**4.5.2 Acute**

- Acute alterations are to be set for no longer than eight hours and are to have a clinical review by the MO prior to having the alteration reset.

#### **4.6 Palliative care and last days of life**

- All palliative or end of life neonates 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 patients' and their families/carers are consulted when determining the appropriate plan when able.

#### **4.7 Cultural Support**

- If the deteriorating neonate is:
  - Aboriginal or Torres Strait Islander, involve Aboriginal Health Worker or family for appropriate family support
  - from a Culturally and Linguistically Diverse (CALD) family, notify the nominated cross-cultural health worker
  - from a non-English speaking background, call the interpreter service: [NSW Ministry of Health Policy Directive PD2017\\_044 – Interpreters – Standards Procedures for Working with Health Care Interpreters.](#)

### **5. CLINICAL EMERGENCY RESPONSE SYSTEMS (CERS)**

- All facilities that admit neonates must have a neonatal CERS plan in place. The agreed CERS program for SESLHD is BTF
- All facilities are to have neonatal 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:
  - All facilities are to use the Clinical Review, Rapid Response and Code Blue process. All calls are to be made dialling 2222
  - R.E.A.C.H. program offers an escalation pathway through the local CERS
  - Clearly outline the escalation model available for parents, families/carer's which enables them to directly escalate to a clinician, if they have any clinical concerns on deterioration
  - All facilities that admit neonates are to have an agreed set of emergency equipment based upon best practice guidelines.

#### **5.1 CERS in specialty areas**

- All speciality areas that require a neonatal CERS response must have localised protocols in place to manage the response
- Any speciality area that is exempt from neonatal CERS (e.g. NICU) must be defined in the local neonatal CERS protocols.

#### **5.2 Patient transfer processes**

- Yellow zone: Patients with observations 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 processes in place for the intra-hospital transfer of patients in the red zone.

### 5.3 Neonatal escalation beyond facility and transfer processes for level 3 and 4 units

- For all neonatal patients who are clinically unstable, deteriorating or for whom there is a high level of clinical concern medical or nursing staff must urgently contact the clinical support or on-call paediatrician to discuss the patient's ongoing care
- This escalation to the consultant is necessary to:
  - Review stabilisation+/- resuscitation requirements for the patient
  - Have a telephone consultation with RHW consultant neonatologist
  - Assess the requirement for NETS transfer to tertiary neonatal service.

### 5.4 Non-hospital / residential care facilities

- Unwell neonates on home midwifery support programs or hospital homebirth service are to return to hospital for a review and/or call an ambulance

## 6. EDUCATION

- Education will be provided as per the [CEC Deteriorating Patient Education Strategy](#)

## 7. REFERENCES

[NSW Ministry of Health Policy Directive PD2017\\_044 - Interpreters- Standard Procedures of working with Health Care Interpreters](#)

[NSW Ministry of Health Guideline GL2018\\_025 - Maternity Fetal Heart Rate Monitoring Guideline](#)

[NSW Ministry of Health Policy Directive PD2020\\_018 - Recognition and management of patients who are Deteriorating](#)

[NSW Health Tiered Network/Operational Plan, 2020](#)

- ## 8. APPENDICES:
1. Key Terms
  2. Minimum number and frequency for vital sign observations



**10. REVISION AND APPROVAL HISTORY**

Date	Revision No.	Author and Approval
January 2014	0	Suzanne Schacht District PACE & Intensive Care Manager & District Women's and Children's Clinical Stream
February 2014	1	Felicity McLaren, RHW PACE CNC.
March 2014	2	Felicity McLaren, RHW PACE CNC.
March 2014	3	Dee Sinclair CMC Clinical Maternity Risk Management
March 2014	3.5	Revised and re-formatted by District Policy Officer.
March 2014	4	Dee Sinclair CMC Clinical Maternity Risk Management & Felicity McLaren, RHW PACE CNC.
April 2014	5	Dee Sinclair CMC Clinical Maternity Risk Management & Felicity McLaren, RHW PACE CNC. Felicity McLaren, RHW PACE CNC
April 2014	6	Dee Sinclair CMC Clinical Maternity Risk Management
April 2014	7	Dee Sinclair CMC Clinical Maternity Risk Management, Felicity McLaren, RHW PACE CNC. Pauline Best Nurse Educator Paediatrics.
May 2014	8	Dee Sinclair CMC Clinical Maternity Risk Management, Felicity McLaren, RHW PACE CNC. Pauline Best Nurse Educator Paediatrics.
May 2014	9	Dee Sinclair CMC Clinical Maternity Risk Management, Felicity McLaren, RHW PACE CNC. Pauline Best Nurse Educator Paediatrics.
May 2014	9.5	District Policy Officer amended 'Policy Statement' section, added references to the relevant National Safety and Quality Health Service Standards and re-formatted procedure.
June 2014	9.5	Submitted to CQC for approval.
June 2014	9.5	Approved by CQC.
May 2018	10	Draft for Comment
June 2018	10	Processed by Executive Services prior to submission to SESLHD Clinical and Quality Council – Major review.
July 2018	10	Endorsed by SESLHD Clinical and Quality Council
April 2021	11	Major review commenced. Rebecca Hughes Deteriorating Patient CNC, Alison Brown CMC WCCS on behalf of the Deteriorating Neonate working party;  Pauline Best Clinical Nurse Educator SGH, Julie Friendship Paediatric Clinical Nurse Consultant , Olivia Taripo A/NUM TSH, Catharine Dias, Clinical Educator, Newborn Care TSH; Louise Everitt CMC, Complex Pregnancy Care SGH , Maria Bulmer A/CMC Risk & Practice Development SGH, Doctor Bob Fonseca Director Paediatrics SGH, Dr Srimi Bolisetty, Co-Director Neonatal Intensive Care RHW, Dr Tim Schindler, Neonatologist RHW.  Draft for comment period.
June 2021	11	Feedback incorporated. Final version approved by Executive Sponsor. To be tabled at June 2021 Clinical and Quality Council for approval.
June 2021	11	Endorsed by SESLHD Clinical and Quality Council

**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](#) (accessed 25/06/2020)

**2 KEY TERMS**

<b>Acute alterations to calling criteria</b>	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.
<b>Additional criteria</b>	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.
<b>Agreed signs of deterioration</b>	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.
<b>Altered calling criteria</b>	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'.
<b>A-G systematic Assessment</b>	A structured approach to physical assessment that considers a patient's <b>A</b> irway, <b>B</b> reathing, <b>C</b> irculation, <b>D</b> isability, <b>E</b> xposure, <b>F</b> luids, <b>G</b> lucose.
<b>Attending Medical Officer (AMO) / Delegated clinician responsible</b>	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.
<b>Balancing measure/s</b>	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.
<b>Behaviour change</b>	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/energy, perception, or emotional state, such as abnormal thinking, irritability, agitation, inconsolability and/or delirium.



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<b>Blue zone</b>	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.
<b>Clinical Emergency Response System (CERS)</b>	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).
<b>CERS Assist</b>	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.
<b>Chronic alteration to calling criteria</b>	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.
<b>Clinical Review</b>	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.
<b>Clinical team responsible for the patient's care</b>	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.
<b>Clinical service</b>	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.
<b>Clinical unit</b>	A subset of a facility or service with a special clinical function.
<b>Clinician/s</b>	Medical, nursing, midwifery and allied health professionals who provide direct patient care.
<b>Deterioration in mental state</b>	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. <sup>(7)</sup>

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<b>Deteriorating Patient Safety Net System</b>	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.
<b>End of life</b>	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 <sup>(10)</sup> .
<b>Facility</b>	A building or structure where healthcare is provided by a public health organisation, such as a hospital, multi-purpose centre or office-based clinic.
<b>Family of measures</b>	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.
<b>Individualised monitoring and assessment plan</b>	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 <sup>(7, 8)</sup> .
<b>ISBAR</b>	An acronym for <b>I</b> ntroduction, <b>S</b> ituation, <b>B</b> ackground, <b>A</b> ssessment, <b>R</b> ecommendation, a structured communication tool.
<b>Last days of life</b>	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.
<b>New onset confusion</b>	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days) <sup>(11)</sup> .
<b>Outcome measure/s</b>	A unit of data that measures whether changes to the system have an impact on the intended recipient and the size of the effect.
<b>Palliative care</b>	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 <sup>(10)</sup> .
<b>Process measure/s</b>	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.

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<b>Public health organisation (PHO)</b>	Local health districts, statutory health corporations and affiliated health organisations (with respect to their recognised services) that provide direct patient care.
<b>Rapid response</b>	An urgent review of a deteriorating patient by a rapid response team (RRT), or designated responder/s, as defined in the local CERS protocol.
<b>R.E.A.C.H</b>	An acronym for <b>Recognise, Engage, Act, Call, Help</b> is on its way. <a href="#">R.E.A.C.H</a> is a CEC program for patients, carers and families to directly escalate concerns about deterioration through the local CERS.
<b>Red zone</b>	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.
<b>Resuscitation Plans</b>	<p>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.</p> <p>A Resuscitation Plan is made:</p> <ul style="list-style-type: none"> <li>• With reference to pre-planning by patients (such as Advance Care Directives or plans)</li> <li>• In consultation with patients, carers and families</li> <li>• Taking account of the patient's current clinical status, as well as their wishes and goals of care.</li> </ul> <p>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 <sup>(12)</sup>.</p>
<b>Special Care Nursery</b>	A clinical unit with space designated for the care of neonates who require additional support, or who need additional monitoring and/or observation <sup>(13,18)</sup> .
<b>Standard calling criteria</b>	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.
<b>Standard clinical tools</b>	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.



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<b>Standard observation chart</b>	Standardised observation chart approved for use by the NSW Ministry of Health. These have been developed for a variety of clinical settings.
<b>Track and trigger tool</b>	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.
<b>Transfer of care</b>	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.
<b>Yellow zone</b>	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**

Table 2 [NSW Ministry of Health Policy Directive PD2020\\_018 - Recognition and management of patients who are deteriorating](#) (accessed 25/06/2020)

Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
<b>Adult inpatients</b>	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).
<b>Mental health acute and subacute</b>	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 <a href="#">Engagement and Observation in Mental Health Inpatient Units PD2017_025</a> .
<b>Mental health non-acute</b>	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.
<b>Hospital in the Home</b>	At least once during each consultation/visit <sup>(17)</sup>	To be determined locally based on the models of care and assessment of risk	
<b>Special Care Nursery</b>	Six (6) times per day at four (4) hourly intervals	Respiratory rate, respiratory distress, oxygen saturation, heart rate, temperature, behaviour change*, pain score	



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Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
<b>Newborn</b>	<p><b>Before leaving the birthing environment</b></p> <p>One (1) full set of vital signs observations and a newborn risk assessment completed</p> <p>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.</p>	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.
<b>Paediatric inpatients</b>	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)
<b>Maternity/antenatal inpatient</b>	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 <a href="#">Maternity – Fetal heart rate monitoring GL2018_025</a>	SMOC is recommended for women greater than twenty (20) weeks gestation and less than six (6) week post-partum.
<b>Maternity/postnatal inpatient with no identified risk factors</b>	<p><b>Before leaving the birth environment</b></p> <p>One (1) full set of vital signs observations and a maternity risk assessment completed.</p>	Respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, level of consciousness, new onset confusion or behaviour change*, accumulated blood loss.	<p>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.</p> <p>Women receiving midwifery care in the home are to be monitored according to local protocol, refer to section 4.6.</p>

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Patient group	Minimum required frequency of assessment	Minimum set of vital sign observations	Comments
<b>Maternity/postnatal inpatient with risk factors</b>	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.
<b>Inpatient sub-acute/long stay/rehabilitation</b>	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
<b>Inpatient palliative care</b>	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
<b>Residents in long term care facilities, such as a multipurpose service (MPS)</b>	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.