

**STANDARD PAEDIATRIC
OBSERVATION CHART**

5 to 11 Years

**Lady Ridgeway Hospital
for Children**

Name:
Age:
BHT Number:

Admission to ETU
Admission to Ward
Admission to ICU

Ward Number:

Date:

Target Parameters:

Respiratory rate:

SpO₂:

Pulse rate:

Systolic BP:

Other:

Date				Date	
Time				Time	
AIRWAY / BREATHING	Respiratory Rate ● (breaths per minute)	60		60	
		55		55	
		50		50	
		45		45	
		40		40	
		35		35	
		30		30	
		25		25	
		20		20	
		15		15	
		10		10	
		5		5	
Respiratory Distress	Severe			Severe	
	Moderate			Mod	
	Mild			Mild	
	Normal			Normal	
SpO ₂ ●	100			100	
	95			95	
	90			90	
	85			85	
	80			80	
	75			75	
Probe Change				Probe Change	
Oxygen	L/min or %			L/min or %	
	Device			Device	
CIRCULATION	Heart Rate ● (beats per minute)	180		180	
		170		170	
		160		160	
		150		150	
		140		140	
		130		130	
		120		120	
		110		110	
		100		100	
		90		90	
		80		80	
		70		70	
60		60			
50		50			
40		40			
Capillary Refill	≥ 3 Seconds			≥ 3 Seconds	
	< 3 Seconds			< 3 Seconds	
Blood Pressure (mmHg) > < SBP is the trigger	160			160	
	150			150	
	140			140	
	130			130	
	120			120	
	110			110	
	100			100	
	90			90	
	80			80	
	70			70	
	60			60	
	50			50	
40			40		
30			30		
20			20		
10			10		
Initials				Initials	

Light Blue: Increase Frequency of Observations Yellow: Clinical Review Red: Rapid Response

Date				Date	
Time				Time	
DISABILITY	Level of Consciousness	Alert		Alert	
		Verbal		Verbal	
		Pain		Pain	
		Unresponsive		Unresponsive	
Enter appropriate letter. A= Alert, V= Rousable only by voice (consider GCS). P= Rousable only by central pain (conduct GCS). U=Unresponsive					
Pain Score	Severe (7-10)			Severe (7-10)	
	Moderate (4-6)			Moderate (4-6)	
	Mild (1-3)			Mild (1-3)	
	Nil			Nil	
EXPOSURE	Temperature (°C) ● (check unit policy)	41		41	
		40.5		40.5	
		40		40	
		39.5		39.5	
		39		39	
		38.5		38.5	
		38		38	
		37.5		37.5	
		37		37	
		36.5		36.5	
		36		36	
		35.5		35.5	
35		35			
34.5		34.5			
34		34			
BGL				BGL	
Weight				Weight	
Initials				Initials	

Interventions at ETU/HDU	Yes / No	Time	Interventions at ETU/HDU	Yes / No	Time
Face mask oxygen	Yes / No		IV antibiotics given	Yes / No	
Nasal prong oxygen	Yes / No		Inotropes	Yes / No	
Initial O ₂ liters/min	Yes / No		IV dextrose given	Yes / No	
Oral airway inserted	Yes / No		IV adrenaline given	Yes / No	
Bag & mask ventilation	Yes / No		Defibrillation	Yes / No	
Already intubated	Yes / No		CPR for shockable rhythm	Yes / No	
Intubated in ETU	Yes / No		CPR for non-shockable	Yes / No	
Nebulization	Yes / No		CPR successful	Yes / No	
IV access obtained	Yes / No		Sent to MICU	Yes / No	
No of IV access attempted	Yes / No		Sent to ward	Yes / No	
IO access obtained	Yes / No		Discharged home	Yes / No	
IV boluses given-	Yes / No		Review appointment	Yes / No	
Maintenance started	Yes / No				

Nurse's notes

Date	Time	Problem/Problems	Intervention / Comments

Doctor's Notes

Name of MO
Name of Registrar

PAEDIATRIC EMERGENCY ASSESMENT RECORD—LADY RIDGEWAY HOSPITAL FOR CHILDREN

Name	Age	Date	DD	M	Y
Address-Town/Village		DOB	DD	M	Y
Time of arrival to hospital		Time of arrival to ETU/OPD	ETU Number		
Mode of arrival	Walking / Three wheeler / public or own vehicle				BHT Number
Source of the pt	Home	OPD	Transferred	Mobile Number	

Assessment by Medical officer in the respective unit: Name of MO: _____ Time _____

Normal level of activity	Alert Mild decrease in activity	Moderate decrease in activity	Marked reduction in activity
Normal behavior & feeding	Sleeping or some/intermittent irritability, consolable	Irritable, agitated, inconsolable Difficulty talking or crying Difficulty feeding /eating	Agitated/ Confused Unable to talk or cry Unable to feed or eat
Respiratory rate	Saturation in air	Saturation with O2	Air entry
Oxygen requirement - nil	Mild O2 requirement	Hypoxaemia corrected by Oxygen	Hypoxaemia may not be corrected by oxygen
Stridor-None	Stridor on exertion	Stridor at rest	Severe Stridor
Accessory muscle use-none	Minimal accessory muscle use	Moderate recession Tracheal tug Nasal Flaring Audible wheezing	Severe recession Gaspng / Grunting Extreme pallor / Cyanosis Absent breath sounds Abdominal breathing
Apnoeic Episodes-none	Abnormal pauses in breathing		Apnoeic episodes (>20 s)
Hydration-Normal	Mild dehydration	Moderate dehydration	Severe Dehydration
Pulse rate	BP	Pulse pressure	
Pulse volume- normal	Pulse-Moderate	Pulse-Thready	Pulse -Not palpable
Line of coldness-none	Up to ankle/Wrist	Mid way up to arm/leg	Up to elbow/knee
Skin colour- normal/pink	Mild pallor	Pale & Mottled	Grey/Cyanosed
CRFT-Normal < 2s	CRFT 2-3 seconds	CRFT 3-4 seconds	CRFT ≥5 s
UOP – How many hours since last UOP?	Number of Vomits for last 24hrs -	Number of Bowel motions for past 24 hours-	
AVPU score -Alert	Response to voice	Response to pain	Unresponsive
Posture – Normal	Floppy	Decorticated	Decerebrated
Pupils- Normal	Equal	Unequal	Reacting to light -Yes/No
Seizures Yes/No	Temperature	Pain Score out of 10-	RBS-

History & other relevant findings

Working diagnosis

Duration of illness

Problems on daily basis and treatment received including drugs

Places where child sought treatment (hospital/GP)

Were there improvements or deteriorations

Reason as to why child brought today

Known medical condition / Regular medications

Known allergies

Problems identified

Investigations: RBS, FBC, Blood culture, Grouping Rh, Urea, SE, SGPT/SGOT, Clotting, Urine FR/culture