Adult

Date: xx/xx/xx
Time: 0800

Score Legend

0	Score 0
1	Score 1
2	Score 2
3	Score 3
4	Score 4
E	Emergency call

(Affix identification label here)

URN: 13579
Family name: WEBB
Given name(s): Sam
Address: 200 Smiles St, Pleasantville
Date of birth: 02 JAN 1960 Sex: ☒ M ☐ F ☐ I

Respiratory Rate (breaths / min) Measure for a full minute	E	≥35
	3	30–34
	2	25–29
	1	21–24
	0	17–20
		13–16
	1	9–12
	E	≤8
O_2 Saturation (%)	0	≥98
		95–97
	1	90–94
	2	85–89
	3	≤84
Oxygen* (L / min *or* % delivered) *If on HF / NIV use % delivered	E	NRM
	3	>11 / >50%
	2	>5–11 / >40–50%
	1	2–5 / 28–40%
	0	<2 / <28%
FM Face mask, HF High flow, NIV Non invasive; NP Nasal prongs, NRM Non re-breather, RA Room air; HFNP High flow nasal prongs	Mode	RA
	High flow rate in L/min	
Blood Pressure (mmHg) Score systolic BP	≥200	
	190s	
	180s	
	170s	
	160s	
	150s	
	140s	
	130s	
	120s	
	110s	
	100s	
	90s	
	80s	
	70s	
	60s	
Systolic BP score		0
Heart Rate (beats / min)	E	≥140
	3	130s
	2	120s
		110s
	1	100s
	0	90s
		80s
		70s
		60s
		50s
	2	40s
	E	30s
Temperature (°C)	2	≥39.5
		38.5–39.4
	1	38–38.4
	0	37.5–37.9
		37–37.4
		36.1–36.9
	1	35.1–36
	2	34.1–35
	3	≤34
Consciousness If necessary, wake patient before scoring	0	**A**lert
	1	**V**oice
	4	New confusion / agitation
	E	**P**ain
		Unresponsive
Modifications in use	M	
TOTAL *Q*-ADDS SCORE		0
Interventions (e.g. 'A')		
Initials		ML

Indicate which systolic BP scoring preference is in use (Usual or Default). If the Usual systolic BP is selected, write the Usual systolic BP in the space provided:
☐ Usual systolic BP: ..... mmHg
☑ Default systolic BP: 120mmHg
Name: Monica Linnane
Signature: MLL
Designation: MO Date: xx/xx/xx

Target Systolic BP (SMO / Registrar ONLY): mmHg
Name:
Signature:
Designation: Date:

Circle the column showing the patient's Usual / Default / Target systolic BP

Actual BP	180s	170s	160s	150s	140s	130s	120s	110s	100s	90s	80s
≥200	EMERGENCY CALL										
190s	0	0	1	1	1	2	2	3	3	4	4
180s	0	0	0	0	1	1	2	2	3	3	4
170s	0	0	0	0	1	1	2	2	3	3	3
160s	1	0	0	0	0	0	1	1	2	2	2
150s	1	1	0	0	0	0	0	1	1	2	2
140s	1	1	1	0	0	0	0	0	1	1	1
130s	2	1	1	0	0	0	0	0	0	0	1
120s	2	2	1	1	0	0	0	0	0	0	0
110s	2	2	2	1	1	0	0	0	0	0	0
100s	3	3	2	2	2	1	1	0	0	0	0
90s	3	3	3	2	2	2	2	1	1	0	0
80s										1	0
70s	EMERGENCY CALL										
60s											

Emergency call if:

- Airway Threat
- Respiratory or cardiac arrest
- Q-ADDS Score ≥8
- Any observation in a purple area (**E**)
- O_2 saturation <90% without response to oxygen
- Seizure >2 minutes
- Sedation score of 3 (severe)
- You are concerned about the patient but they do not fit the above criteria

Actions Required for Tertiary and Secondary Facilities

Q-ADDS Score	Observations (minimum frequency)	Notify	Escalate (if no review)	Intra-hospital Escort
0	8 hourly			
1–3	4 hourly	• Team Leader		
4–5	1 hourly	• Team Leader • Resident review within 30 minutes	• If no review after 30 minutes call Registrar	Nurse
6–7	½ hourly	• Team Leader • Registrar review within 30 minutes	• If no review after 30 minutes, or if concerned, initiate Emergency Call, notify Consultant and Nurse Manager	Nurse
≥8 or E	10 minutely	• Initiate Emergency Call • Registrar to ensure Consultant is notified	• Registrar to ensure Consultant is notified	Nurse and Medical Officer

Interventions Relating to observations from page 2 or the Pain at Rest Table on page 4

If an intervention is administered, record here and note letter in *Intervention* row on page 2 in appropriate time column

A
B
C
D
E
F
G

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v6.00 - 09/2016
Mat. No.: 10234583
SW150

TRAINING ONLY

Queensland Government

Queensland Adult Deterioration Detection System (*Q*-ADDS)

For tertiary and secondary facilities

Facility: QUni Hospital

General Instructions

» You must record all observations including Pain, Functional Activity Scale and Sedation scores (p4) at a frequency appropriate to the patient's clinical condition.
» You must calculate a *Total Q-ADDS Score* for each set of observations and record it in the Total Q-ADDS Score box, even if the score is zero. (Respiratory Rate + O_2 Saturation + O_2 Flow Rate + Blood Pressure + Heart Rate + Temperature + Consciousness).
» A Target systolic BP can be documented in the appropriate box on page 3 by the treating Registrar or SMO. The Target systolic BP will supersede the Usual systolic BP.
» If there is no Target systolic BP the nurse admitting the patient should determine the patient's Usual systolic BP and record it in the appropriate box on page 3. If the Nurse is unable to determine the patient's usual BP tick the "Default systolic BP: 120mmHg" box on page 3.
» When graphing observations, place a dot (•) in the appropriate box and join to the preceding dot (e.g.). For blood pressure, use the symbols indicated ( ). You must write any observation outside the range of the graph as a number.

Modifications for Patients with Chronic Abnormal Physiology

» Modifications can ONLY be made on the basis of chronic abnormal physiology. That is, physiological parameters that are usual for the patient at home.
» Modifications must be authorised by a SMO / registrar / PHO (or equivalent).
» NB: document the letter "M" in the row above the Total Q-ADDS Score on page 2 to indicate modifications in use.

Diagnosis which justifies modification (e.g. chronic obstructive pulmonary disease):

Authorised by (SMO / registrar / PHO):

Doctor's name (please print):

Designation:	Signature:
Date:	Time:

Write the acceptable range (will score zero) below:

Respiratory Rate	to	breaths / min
O_2 Saturation	to	%
O_2 Flow Rate	to	L / min
Heart Rate	to	beats / min

Scoring note: for observations outside the modified range, revert to the original score on Q-ADDS.

For example: if an O_2 saturation of 90–94% is tolerated (score of zero), and the O_2 saturation falls to 89%, it would score 2.

NB: document the letter 'M' in the row above the Total Q-ADDS Score on page 2 to indicate modifications in use.

Temporary Modifications

» Temporary Modification can only be made to **ONE** of the following - Blood Pressure, Heart Rate or Respiratory Rate
» Must have explanation and detailed management plan documented by Medical Officer (MO) in the case notes (headed: "Temporary Modification Plan 1, 2 or 3").
» Caution should be exercised in prescribing Temporary Modifications for patients with **suspected Sepsis**.
» Temporary modifications must be authorised by the SMO accountable for the patient or after consultation between at least two members of the Medical Emergency Team.
» Each modification will last a maximum of 2 hours (1 box), sequential modifications are permitted for maximum 6 hours (all 3 boxes) but only 1 box can be completed for each MO review (i.e. MUST have MO review every 2 hours and modification prescribed into next box).
» A Total Q-ADDS Score must be documented at least every 30 minutes.
» Document the letter "M" in the row above the Total Q-ADDS Score on page 2 to indicate modifications in use.

Temporary Modification 1		**Temporary Modification 2**		**Temporary Modification 3**	
Write the acceptable range (will score zero)		Write the acceptable range (will score zero)		Write the acceptable range (will score zero)	
Systolic BP	to mmHg	Systolic BP	to mmHg	Systolic BP	to mmHg
	(can NOT be modified <80 mmHg)		(can NOT be modified <80 mmHg)		(can NOT be modified <80 mmHg)
OR Heart Rate	to beats / min	***OR*** Heart Rate	to beats / min	***OR*** Heart Rate	to beats / min
OR Resp. Rate	to breaths / min	***OR*** Resp. Rate	to breaths / min	***OR*** Resp. Rate	to breaths / min
	(can NOT be modified >34 bpm)		(can NOT be modified >34 bpm)		(can NOT be modified >34 bpm)
Modifying Doctor Name:		**Modifying Doctor** Name:		**Modifying Doctor** Name:	
Authorising Doctor Name:		**Authorising Doctor** Name:		**Authorising Doctor** Name:	
Start Date: / Time:		**Start** Date: / Time:		**Start** Date: / Time:	
Cease Date: / Time:		**Cease** Date: / Time:		**Cease** Date: / Time:	
Contact number:		Contact number:		Contact number:	

Q-ADDS

TERTIARY AND SECONDARY

Pain and Sedation Assessment

- If the patient reports any level of chest pain, please follow local chest pain procedure
- If you are concerned about the patient's pain but they do not fit the below criteria notify Medical Officer
- If documenting pain and sedation on a PCA/Epidural Monitoring form, this section does not need to be completed

(Affix identification label here)

URN: 13579
Family name: WEBB
Given name(s): Sam
Address: 200 Smiles St Pleasantville
Date of birth: 01 JAN 1960 Sex: ☑ M ☐ F ☐ I

		Date / Time
Pain Score at Rest		
Severe	10	
	9	
	8	
	7	
Moderate	6	
	5	
	4	
Mild	3	
	2	
	1	
None	0	
Functional Activity Scale (FAS) Score (perform during cough / movement)		
Activity severely limited by pain	C	
Activity mild to moderately limited by pain	B	
Activity unlimited by pain	A	
Interventions (document on page 3 e.g. 'B')		

**** If scores conflict, follow the highest score***

☐ • Notify team leader • Administer analgesia • Notify medical officer to review if no improvement within 30 minutes of administering analgesia	☐ • Administer analgesia • Consider team leader / medical officer review if no improvement within 60 minutes of analgesia	☐ • Consider simple analgesia

Sedation Score (for patients receiving potentially sedating medication)		
Patient **must** be woken to assess sedation score Note: **DO NOT** add the Sedation Score to the Q-ADDS Score. Follow actions below.	0 1 2 3	
0 = Awake	• Continue to monitor patient's Q-ADDS, Sedation and Pain Score in accordance with individual monitoring plan	
1 = Mild (easy to rouse, able to keep eyes open for 10 secs)	• Increase monitoring of Q-ADDS, Sedation and Pain score • Recheck Sedation score before administering potentially sedating medication	
2 = Moderate (rouseable, but unable to keep eyes open for 10 secs)	• Ensure patient receives oxygen and monitor oxygen saturation • Withhold additional sedating medication (until medical review) • Notify team leader	• Notify medical officer to review within 15 minutes (remain with patient until review) • Monitor Q-ADDS, Sedation and Pain score (minimum 15 minutely) • If concerned, initiate Emergency Response
3 = Severe (difficult to rouse or un-rouseable)	• Initiate Emergency Response • Ensure patient receives oxygen and monitor oxygen saturation • Determine need for reversal agent (naloxone, flumazenil)	

Additional Observations

		Date / Time
Height (cm)	Bowels	
	Passed urine	
	Weight (kg)	
Other (e.g. urinalysis)		

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