



Queensland Adult Deterioration Detection System (Q-ADDS) For tertiary and secondary facilities

Facility: CUuni Hospital

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: M F I

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 + O₂ Saturation + O₂ 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):

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

Authorised by (SMO / registrar / PHO):

Doctor's name (please print):

Designation: Signature:
Date: Time:

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

For example: if an O₂ saturation of 90–94% is tolerated (score of zero), and the O₂ 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.

Q-ADDS

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

Write the acceptable range (will score zero)

Systolic BP	to	mmHg
OR	(can NOT be modified <80 mmHg)	
Heart Rate	to	beats / min
OR		
Resp. Rate	to	breaths / min
	(can NOT be modified >34 bpm)	

Modifying Doctor Name:

Authorising Doctor Name:

Start Date: Time:

Cease Date: Time:

Contact number:

Temporary Modification 2

Write the acceptable range (will score zero)

Systolic BP	to	mmHg
OR	(can NOT be modified <80 mmHg)	
Heart Rate	to	beats / min
OR		
Resp. Rate	to	breaths / min
	(can NOT be modified >34 bpm)	

Modifying Doctor Name:

Authorising Doctor Name:

Start Date: Time:

Cease Date: Time:

Contact number:

Temporary Modification 3

Write the acceptable range (will score zero)

Systolic BP	to	mmHg
OR	(can NOT be modified <80 mmHg)	
Heart Rate	to	beats / min
OR		
Resp. Rate	to	breaths / min
	(can NOT be modified >34 bpm)	

Modifying Doctor Name:

Authorising Doctor Name:

Start Date: Time:

Cease Date: Time:

Contact number:

TERTIARY AND SECONDARY

Pain and Sedation Assessment

(Affix identification label here)

- 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

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																								
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	
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

- | | | |
|---|--|---|
| <input type="checkbox"/> • Notify team leader | <input type="checkbox"/> • Administer analgesia | <input type="checkbox"/> • Consider simple analgesia |
| <input type="checkbox"/> • Administer analgesia | <input type="checkbox"/> • Notify medical officer to review if no improvement within 30 minutes of administering analgesia | <input type="checkbox"/> • Consider team leader / medical officer review if no improvement within 60 minutes of analgesia |

Sedation Score (for patients receiving potentially sedating medication)

	Date	Time																								
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	
Patient must be woken to assess sedation score	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																								
		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	
Height (cm)																										
Bowels Passed urine																										
Weight (kg)																										
Other (e.g. urinalysis)																										

DO NOT WRITE IN THIS BINDING MARGIN