

AUGUST 24

Implementation of revised Adult RDR ED chart (MR59A – ED)



EMERGENCY DEPARTMENT ADULT RDR CHART (MR 59A – ED)

PATIENT LABEL
Unit Record No.:
Surname:
Given Names:
Date of Birth: Sex:

MEDICAL EMERGENCY RESPONSE (MER) CALL

RESPONSE CRITERIA – If one or more observations are in the purple zone, or one or more of the following are occurring:

- You are worried about the patient
- A patient or consumer is worried
- Respiratory or cardiac arrest
- Threatened airway
- Significant bleeding
- Unexpected or uncontrolled seizure
- Delayed MDT review (> 30 minutes)
- Place emergency call and specify location
- Initiate basic/advanced life support
- Notify senior doctor responsible for patient
- Increase frequency of observations post intervention. Take advice from MER team

Refer to ACD or 7 Step Pathway - Resuscitation Plan if MER call required

MULTI DISCIPLINARY TEAM (MDT) REVIEW (Minimum team of registered nurse/midwife and medical practitioner)

RESPONSE CRITERIA – If one or more observations are in the red zone, or one or more of the following are occurring:

- You are worried about the patient
- A patient or consumer is worried
- Unrelieved chest pain
- Urine output < 30mL/hr over 4 hours from patient with IDC, or patient has not voided for over 12 hours (unless intra-dialysis)
- Delayed RN/RM review (> 30 minutes)
- Escalate to MER call if there are 3 or more observations in red zone.
- MDT review must occur within 30 minutes (Country Hospitals refer to local guidelines) or escalate to MER call
- Increase frequency of observations to hourly. Escalate if there are ongoing fluctuations
- Review SpO₂ and O₂ flow rate requirements

REGISTERED NURSE OR REGISTERED MIDWIFE (and notify Shift Coordinator)

RESPONSE CRITERIA – If one or more observations are in the yellow zone, or one or more of the following are occurring:

- You are worried about the patient
- A patient or consumer is worried
- New or unexplained behavioural change
- Intra-dialysis BP drop > 20mmHg from baseline
- For new or unexpected pain or 2 pain scores 8-10 within 1 hour, senior nurse to review and consider MDT review if required.
- Escalate to MDT review if there are 3 or more observations in yellow zone.
- Registered nurse/midwife review must occur within 30 minutes, or escalate to MDT review
- Increase frequency of observations
- Manage anxiety, pain and other symptoms
- Review SpO₂ and O₂ flow rate requirements
- For new or unexpected pain or 2 consecutive pain scores 8-10 within 1 hour, Senior nurse to request MDT review if required

Level of Consciousness / Sedation

Score	Descriptor	Stimulus	Response	Duration
3	Difficult to rouse	Pain, shoulder squeeze	Brief eye opening OR any movement OR no response	N/A
2	Easy to rouse, difficulty staying awake	Voice, light touch	Eye opening and eye contact	<10 seconds
1	Easy to rouse	Voice, light touch	Eye opening and eye contact	>10 seconds
0	Awake, Alert when approached	N/A	N/A	N/A

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HISTORY OF PRESENTING COMPLAINT: Date: / / Time:

ASSESSMENT FINDINGS:

BROUGHT IN BY: SAAS SAPOL WALK IN FROM: HOME LLOC HLOC OTHER: _____

MENTAL HEALTH STATUS: Voluntary Section 56 Section 57 ITO CTO

PAST MEDICAL HISTORY: _____

ALLERGIES: _____

RELEVANT MEDICATIONS: _____

INFECTIOUS STATUS: _____

A. AIRWAY
Patent Compromised Assisted Interventions: _____
Cervical Spine Immobilised: Yes No N/A

B. BREATHING
Breath Sounds: Normal Wheeze Stridor Severe
Dyspnoea: None Mild Moderate Non-Productive Productive Non-Productive Severe
Cough: None Nasal Mask NRM _____ L/Min

C. CIRCULATION
Skin: Warm & Dry Pale Flushed Diaphoretic Cyanotic
Pulse: Regular Irregular

D. DISABILITY
Eyes: 4 Open Spontaneously 5 Orientated 6 Obeys Command
 3 Open to Speech 4 Confused 5 Localises to Pain
 2 Open to Pain 3 Inappropriate Words 4 Withdraws to Pain
 1 Closed 2 Incomprehensible 3 Decerebrate Flexion
 1 None 2 Decerebrate Extension 1 No Movement

Pupils: Size: R L Baseline Limb Strengths: Arm Strength (NP, MW, SW, NR) Leg Strength (NP, MW, SW, NR)

ECG: Time: _____ Troponin: _____ Time: _____ Location: _____
 NIPP IV Cannula Time: _____ Size: _____ Location: _____
 Nurse Initial Pathology U/A Yes No BHCg Positive Negative

Designation: _____ First set of Observations completed ID confirmed Wrist band applied

Nurse's Name: _____ Signature: _____

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Chart Number: _____

General Instructions

You must record a set of observations including a minimum of respiratory rate, blood pressure, pulse rate, temperature, oxygen saturation and level of consciousness/sedation:

- On admission.
- At a frequency appropriate for the patients clinical state but not less than once/shift for acute inpatients.
- As per local procedures with a minimum of once daily for patient's awaiting discharge placement.
- If the patient is deteriorating or an observation is in a shaded area.
- Whenever you are worried about the patient.
- If required.
- Review is required for 2 or more new/unexpected pain within the hour or 2 consecutive pain scores of 8-10 within the hour despite medication administration.

When graphing observations, place a dot (•) in the centre of the box which includes the current observation in its range of values and connect it to the previous dot with a straight line. If observations fall above or below the graphic parameters, write the value in the relevant box. For systolic blood pressure, use the symbol indicated on the graphic chart.

Whenever an observation falls within a shaded area, you must initiate the actions required for that colour, unless a modification has been made by a RMO or more senior doctor.

Modifications

If abnormal observations are to be tolerated for the patient's clinical condition, write the acceptable ranges and rationale (where a response will not be triggered) below. Duration of modification must be specified. Check ACD and 7 Step Pathway - Resuscitation Plan.

	Modification 1	Modification 2	Modification 3	Modification 4
Start Date and Time	/ /	/ /	/ /	/ /
Finish Date and Time	: :	: :	: :	: :
Duration				
Triggers for MDT review				
Triggers for MER call				
Doctor's Signature				
Doctor's Name (print)				
Doctor's Designation				
Nurse/Midwife Signature				
Nurse/Midwife Name (print)				
Nurse/Midwife Designation				

RESUSCITATION

7 Step Pathway - Resuscitation Plan (MR RESUS) Current In Progress No plan 7 Step Pathway - Resuscitation Plan needs review In Medical Record In MyHealth Record

Advance Care Directive (ACD) A patient who is at the end of their life and is not for resuscitation may still require urgent medical response for symptom management. Refer to current MR RESUS or Advance Care Directives for instructions / patients wishes regarding MER call, CPR and other treatment limitations. Other advance care plan

- > All SA Health sites adopt the revised adult RDR chart (MR59A), Adult RDR ED (MR59A – ED), and the equivalent in Sunrise on 24 August.
- > The revised charts meet the requirements of Standard 8: Recognising and Responding to Acute Deterioration from the National Safety and Quality Health Service Standards

- > SA Health staff can access education resources and view the revised Adult Rapid Detection and Response (RDR) Observation Chart on the SA Health website or for education resources and charts, visit www.sahealth.sa.gov.au/RDRCharts.

Site Contacts

Project Contact

