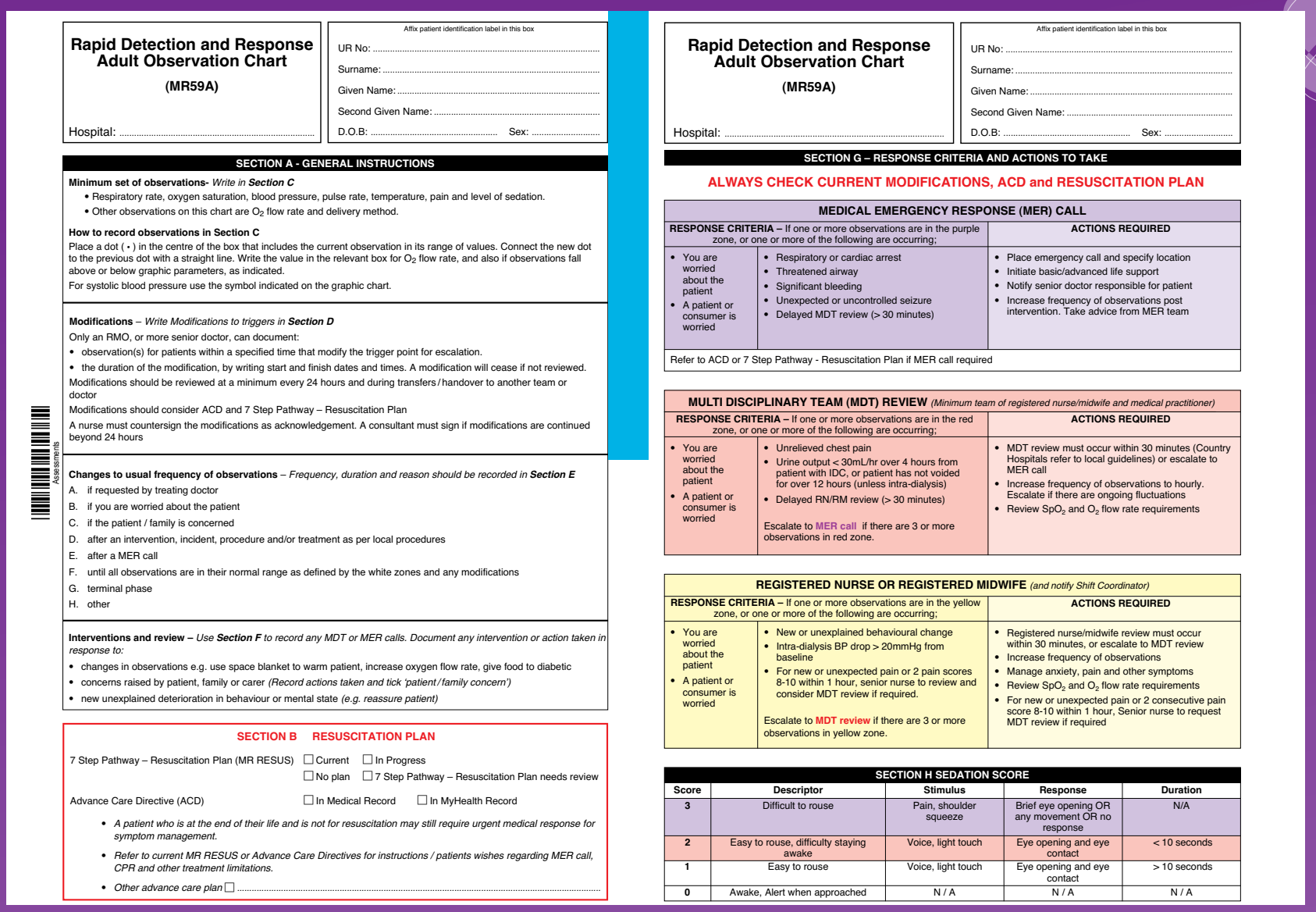
AUGUST 24

Implementation of revised Adult RDR chart (MR59A)



Rapid Detection and Response Adult Observation Chart

(MR59A)

Hospital: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

SECTION A - GENERAL INSTRUCTIONS

Minimum set of observations- *Write in* ***Section C***

- Respiratory rate, oxygen saturation, blood pressure, pulse rate, temperature, pain and level of sedation.
- Other observations on this chart are O_2 flow rate and delivery method.

How to record observations in Section C

Place a dot (•) in the centre of the box that includes the current observation in its range of values. Connect the new dot to the previous dot with a straight line. Write the value in the relevant box for O_2 flow rate, and also if observations fall above or below graphic parameters, as indicated.

For systolic blood pressure use the symbol indicated on the graphic chart.

Modifications – *Write Modifications to triggers in* ***Section D***

Only an RMO, or more senior doctor, can document:

- observation(s) for patients within a specified time that modify the trigger point for escalation.
- the duration of the modification, by writing start and finish dates and times. A modification will cease if not reviewed.

Modifications should be reviewed at a minimum every 24 hours and during transfers / handover to another team or doctor

Modifications should consider ACD and 7 Step Pathway – Resuscitation Plan

A nurse must countersign the modifications as acknowledgement. A consultant must sign if modifications are continued beyond 24 hours

Assessments

Changes to usual frequency of observations – *Frequency, duration and reason should be recorded in* ***Section E***

A. if requested by treating doctor
B. if you are worried about the patient
C. if the patient / family is concerned
D. after an intervention, incident, procedure and/or treatment as per local procedures
E. after a MER call
F. until all observations are in their normal range as defined by the white zones and any modifications
G. terminal phase
H. other

Interventions and review – *Use* ***Section F*** *to record any MDT or MER calls. Document any intervention or action taken in response to:*

- changes in observations e.g. use space blanket to warm patient, increase oxygen flow rate, give food to diabetic
- concerns raised by patient, family or carer *(Record actions taken and tick 'patient / family concern')*
- new unexplained deterioration in behaviour or mental state *(e.g. reassure patient)*

SECTION B RESUSCITATION PLAN

7 Step Pathway – Resuscitation Plan (MR RESUS) ☐ Current ☐ In Progress ☐ No plan ☐ 7 Step Pathway – Resuscitation Plan needs review

Advance Care Directive (ACD) ☐ In Medical Record ☐ In MyHealth Record

- *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* ☐ .....

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SECTION G – RESPONSE CRITERIA AND ACTIONS TO TAKE

ALWAYS CHECK CURRENT MODIFICATIONS, ACD and RESUSCITATION PLAN

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;		**ACTIONS REQUIRED**
• 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;		**ACTIONS REQUIRED**
• 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 SpO_2 and O_2 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;		**ACTIONS REQUIRED**
• 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 SpO_2 and O_2 flow rate requirements • For new or unexpected pain or 2 consecutive pain score 8-10 within 1 hour, Senior nurse to request MDT review if required

SECTION H SEDATION SCORE

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

› **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

Government of South Australia
SA Health