### Q-ADDS Score

#### Score Legend

- **Score 0**
- **Score 1**
- **Score 2**
- **Score 3**
- **Score 4**
- **Emergency call**

#### Actions Required for Tertiary and Secondary Facilities

- **Q-ADDS Score (minimum frequency)**
- **Notify**
- **Escalate**
- **Intra-hospital Escort**

<table>
<thead>
<tr>
<th>Score</th>
<th>Observations (minimum frequency)</th>
<th>Notify</th>
<th>Escalate</th>
<th>Escort</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8 hourly</td>
<td>Team Leader</td>
<td>If no review after 30 minutes call Registrar</td>
<td>Nurse</td>
</tr>
<tr>
<td>1-3</td>
<td>4 hourly</td>
<td>Team Leader</td>
<td>If no review after 30 minutes call Registrar</td>
<td>Nurse</td>
</tr>
<tr>
<td>4-5</td>
<td>1 hourly</td>
<td>Resident review within 30 minutes</td>
<td>If no review after 30 minutes, or if concerned, initiate Emergency Call, notify Consultant and Nurse Manager</td>
<td>Nurse</td>
</tr>
<tr>
<td>6-7</td>
<td>½ hourly</td>
<td>Registrar review within 30 minutes</td>
<td>If no review after 30 minutes, or if concerned, initiate Emergency Call, notify Consultant and Nurse Manager</td>
<td>Nurse</td>
</tr>
<tr>
<td>28 or E</td>
<td>10 minutely</td>
<td>Initiate Emergency Call</td>
<td>Registrar to ensure Consultant is notified</td>
<td>Nurse and Medical Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Registrar to ensure Consultant is notified</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- A
- B
- C
- D
- E
- F
- G

#### Modifications in use

- M

---

**Adult**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Respiratory Rate (breaths / min)</th>
<th>O2 Saturation (%)</th>
<th>Oxygen* (L/min or % delivered)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>E 235</td>
<td></td>
<td>NG</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 37-39</td>
<td></td>
<td>&gt;50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 40-45</td>
<td></td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 100s</td>
<td></td>
<td>NRM</td>
</tr>
</tbody>
</table>

#### Score systolic BP

<table>
<thead>
<tr>
<th>Score systolic BP</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>EMERGENCY CALL</td>
</tr>
</tbody>
</table>

#### Systolic BP score

- **E 210s**
- **E 190s**
- **E 170s**
- **E 160s**
- **E 140s**
- **E 120s**
- **E 110s**
- **E 100s**
- **E 90s**
- **E 80s**
- **E 70s**
- **E 60s**

#### Heart Rate (beats / min)

- **E 238 5**
- **E 37-39 5**
- **E 37-37 4**
- **E 34-35 3**

#### Temperature (°C)

- **E 34.1-35 3**
- **E 34.1-35 3**
- **E 34.1-35 3**

#### Conscience

- **E Alert**
- **E Voice**
- **E New confusion / agitation**
- **E Pain**
- **E Unresponsive**

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**Interventions**

- A
- B
- C
- D
- E
- F
- G

---

**Modifications in use**

- M

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**TOTAL Q-ADDS SCORE**

- 3

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**Initials**

- [ ]

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**Page 2 of 4**
**General Instructions**

- You must record all observations including Pain, Functional Activity Scale and Sedation scores on a copy of the 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 document 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: 120/80 mmHg” box on page 3.
- When graphing observations, place a dot (•) in the appropriate box and join 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
- **O2 Saturation** to %
- **O2 Flow Rate** to L / min
- **Heart Rate** to beats / min

**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 (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 completed at least every 30 minutes.

**Temporary Modification 1**

- Document the letter “M” in the row above the Total Q-ADDS Score on page 2 to indicate modifications in use.

**Temporary Modification 2**

- **Systolic BP** OR **Heart Rate** OR **Resp. Rate**
  - to mmHg
  - to beats / min
  - to breaths / min

**Temporary Modification 3**

- **Systolic BP** OR **Heart Rate** OR **Resp. Rate**
  - to mmHg
  - to beats / min
  - to breaths / min

**Temporary Modification 4**

- Write the acceptable range (will score zero) below:

**Additional Observations**

- **Height (cm)**
- **Weight (kg)**
- **Other** (e.g. urinalysis)

**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

**Date:**

**Time:**

**Pain Score at Rest**

<table>
<thead>
<tr>
<th>Severe</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>6</td>
</tr>
<tr>
<td>Mild</td>
<td>3</td>
</tr>
</tbody>
</table>

**Functional Activity Scale (FAS) Score (perform during quiet assessment)**

- Activity severely limited by pain
- Activity mild to moderately limited by pain
- Activity unlimited by pain

**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.

<table>
<thead>
<tr>
<th>Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Continue to monitor patient’s Q-ADDS, Sedation and Pain Score in accordance with individual monitoring plan</td>
</tr>
<tr>
<td>1</td>
<td>Increase monitoring of Q-ADDS, Sedation and Pain score</td>
</tr>
<tr>
<td>2</td>
<td>Recheck Sedation score before administering potentially sedating medication</td>
</tr>
<tr>
<td>3</td>
<td>Initiate Emergency Response</td>
</tr>
<tr>
<td>4</td>
<td>Ensure patient receives oxygen and monitor oxygen saturation</td>
</tr>
<tr>
<td>5</td>
<td>Notify medical officer to review within 15 minutes (remain with patient until review)</td>
</tr>
<tr>
<td>6</td>
<td>Monitor Q-ADDS, Sedation and Pain score (minimum 15 minutes)</td>
</tr>
<tr>
<td>7</td>
<td>If concerned, initiate Emergency Response</td>
</tr>
</tbody>
</table>

**Emergency Response**

- Notify team leader
- Administer analgesia
- Notify medical officer to review if no improvement within 60 minutes of analgesia
- Consider team leader / medical officer review if no improvement within 60 minutes of analgesia
- Consider simple analgesia

**Date:**

**Time:**

- **Notify team leader**
- **Administer analgesia**
- **Consider team leader / medical officer review if no improvement within 60 minutes of analgesia**
- **Consider simple analgesia**

**Contact number:**

**Authorising Doctor Name:**

**Modifying Doctor Name:**

**URN:** 241802

**Family name:** Thorne

**Given name(s):** Alex

**Address:** 2A Unity Drive, Pleasenville

**Sex:** M

**Date of birth:** 01 JAN 1924