## Q-ADDS Interventions

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notify</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Escalate</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
<tr>
<td>Intra-hospital Escort</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
<td>E</td>
</tr>
</tbody>
</table>

### Actions Required for Tertiary and Secondary Facilities

#### Q-ADDS Score

<table>
<thead>
<tr>
<th>Observations (minimum frequency)</th>
<th>Notify</th>
<th>Escalate</th>
<th>Intra-hospital Escort</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>Team Leader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-5</td>
<td>Team Leader</td>
<td>Resident review within 30 minutes</td>
<td>Nurse</td>
</tr>
<tr>
<td>6-7</td>
<td>Team Leader</td>
<td>Registrar review within 30 minutes</td>
<td>Nurse</td>
</tr>
</tbody>
</table>

#### 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

### Modifications in Use

- M

### Total Q-ADDS Score

<table>
<thead>
<tr>
<th>(e.g. A)</th>
<th>D</th>
</tr>
</thead>
</table>

### Interventions

- ML
**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.

**Temporary Modifications**

- 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):**

<table>
<thead>
<tr>
<th>Write the acceptable range (will score zero):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respiratory Rate</strong> to breaths/min</td>
</tr>
<tr>
<td><strong>O₂ Saturation</strong> to %</td>
</tr>
<tr>
<td><strong>O₂ Flow Rate</strong> to L/min</td>
</tr>
<tr>
<td><strong>Heart Rate</strong> to beats/min</td>
</tr>
</tbody>
</table>

**Authorised by (SMO / registrar / PHO):**

**Doctor’s name (please print):**

**Designation:**

**Signature:**

**Date:**

**Time:**

**Temporary Modifications**

- Temporary Modification can only be made to ONE of the following - Blood Pressure, Heart Rate or Respiratory Rate.
- You 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.

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

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</tr>
</tbody>
</table>

**Authorised by (SMO / registrar / PHO):**

**Doctor’s name (please print):**

**Designation:**

**Signature:**

**Date:**

**Time:**

**Temporary Modifications**

- 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**

<table>
<thead>
<tr>
<th>Write the acceptable range (will score zero):</th>
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<tbody>
<tr>
<td><strong>Systolic BP OR</strong> to mmHg</td>
</tr>
<tr>
<td><strong>Heart Rate</strong> to beats/min</td>
</tr>
<tr>
<td><strong>Resp. Rate</strong> to breaths/min</td>
</tr>
</tbody>
</table>

**Modifying Doctor Name:**

**Authorising Doctor Name:**

**Start Date:**

**Time:**

**Cease Date:**

**Time:**

**Contact number:**

**Temporary Modification 2**

<table>
<thead>
<tr>
<th>Write the acceptable range (will score zero):</th>
</tr>
</thead>
<tbody>
<tr>
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<td><strong>Heart Rate</strong> to beats/min</td>
</tr>
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<td><strong>Resp. Rate</strong> to breaths/min</td>
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</table>

**Modifying Doctor Name:**

**Authorising Doctor Name:**

**Start Date:**

**Time:**

**Cease Date:**

**Time:**

**Contact number:**

**Temporary Modification 3**

<table>
<thead>
<tr>
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<tr>
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**Modifying Doctor Name:**

**Authorising Doctor Name:**

**Start Date:**

**Time:**

**Cease Date:**

**Time:**

**Contact number:**

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**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**

- **Severe**
- **Moderate**
- **Mild**
- **None**

**Functional Activity Scale (FAS) Score (performed during quarantined admission)**

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

**Interventions (document on page 3 e.g. ‘B’)**

- **If scores conflict, follow the highest score**
- **Administer analgesia**
- **Consider team leader / medical officer review if no improvement within 60 minutes of 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 = Awake**
- **1 = Mild (easy to rouse, able to keep eyes open for 10 secs)**
- **2 = Moderate (routinely unable to keep eyes open for 10 secs)**
- **3 = Severe (difficult to rouse or un-routinely)**

**Additional Observations**

**Date:**

**Time:**

**Height (cm):**

**Bloods:**

**Passed urine:**

**Weight (kg):**

**Other (e.g. urinalysis):**