Government of South Australia
SA Health

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

PATIENT LABEL

UR No:
Surname:
Given Name:
Second Given Name:
Date of Birth: Sex/Gender:

Hospital/Site:

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. 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

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:

☐ **DOCUMENTED ON ALERT MR0**

RELEVANT MEDICATIONS:

NEXT OF KIN:
Contact 1:
Relationship:
Phone No:
Mobile:

INFECTIOUS STATUS:

A. AIRWAY
☐ **Patent** ☐ **Compromised** ☐ **Assisted** **Interventions:**
Cervical Spine Immobilised: ☐ Yes ☐ N/A

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

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

D. DISABILITY
Eyes
☐ 4 Open Spontaneously
☐ 3 Open to Speech
☐ 2 Open to Pain
☐ 1 Closed

Best Verbal Response
☐ 5 Orientated
☐ 4 Confused
☐ 3 Inappropriate Words
☐ 2 Incomprehensible
☐ 1 None

Best Motor Response
☐ 6 Obeys Command
☐ 5 Localises to Pain
☐ 4 Withdraws to Pain
☐ 3 Decorticate Flexion
☐ 2 Decerebrate Extension
☐ 1 No Movement

Pupils

	R	L
Size		
Reaction		

Baseline Limb Strengths

Arm Strength				Leg Strength			
NP	MW	SW	NR	NP	MW	SW	NR

GCS Total /15

ECG ☐ Time..... **Troponin** ☐ Time.....
☐ **NIXR** ☐ **IV Cannula** Time: ..... Size: ..... 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* ☐ .....

Assessments

Observation Chart

MER | MDT | RN / RM

Parameter	Left label	Right label
Year / Date		
Time		
Respiratory Rate *(breaths/min)*	Write ≥ 36 (MER)	Write ≥ 36
	31 - 35 (MER)	31 - 35
	26 - 30 (MDT)	26 - 30
	21 - 25 (RN/RM)	21 - 25
	16 - 20	16 - 20
	11 - 15	11 - 15
	8 - 10 (RN/RM)	8 - 10
	Write ≤ 7 (MER)	Write ≤ 7
O_2 Saturation *(%)*	≥ 98	≥ 98
	95 - 97	95 - 97
	92 - 94 (RN/RM)	92 - 94
	89 - 91 (MDT)	89 - 91
	Write ≤ 88 (MER)	Write ≤ 88
O_2 Flow Rate *(L/min)* Write value:	Write > 8 (MER)	Write > 8
	Write 7 - 8 (MDT)	Write 7 - 8
	Write 5 - 6 (RN/RM)	Write 5 - 6
	Write 0 - 4	Write 0 - 4
Delivery Method/Air		
Blood Pressure *(mmHg)* Use systolic blood pressure as trigger for response	Write ≥ 200s (MER)	Write ≥ 200s
	190s (MDT)	190s
	180s (MDT)	180s
	170s (RN/RM)	170s
	160s	160s
	150s	150s
	140s	140s
	130s	130s
	120s	120s
	110s	110s
	100s	100s
	90s (MDT)	90s
	80s (MER)	80s
	70s (MER)	70s
	60s (MER)	60s
	50s (MER)	50s
	Write ≤ 40 (MER)	Write ≤ 40
Heart Rate *(beats/min)*	Write ≥ 140 (MER)	Write ≥ 140
	130s (MDT)	130s
	120s (MDT)	120s
	110s (RN/RM)	110s
	100s (RN/RM)	100s
	90s	90s
	80s	80s
	70s	70s
	60s	60s
	50s (RN/RM)	50s
	40s (MDT)	40s
	Write ≤ 30 (MER)	Write ≤ 30
Temperature *(°C)*	Write ≥ 39.1 (MDT)	Write ≥ 39.1
	38.6 - 39.0 (RN/RM)	38.6 - 39.0
	38.1 - 38.5 (RN/RM)	38.1 - 38.5
	37.6 - 38.0	37.6 - 38.0
	37.1 - 37.5	37.1 - 37.5
	36.6 - 37.0	36.6 - 37.0
	36.1 - 36.5	36.1 - 36.5
	35.6 - 36.0	35.6 - 36.0
	35.1 - 35.5 (RN/RM)	35.1 - 35.5
	Write ≤ 35 (MDT)	Write ≤ 35
Sedation Score Refer to table on page 5	3 (MER)	3
	2 (MDT)	2
	1	1
	0	0
New/Unexpected pain (2 or more pain scores of 8-10 within 1 hour require review see page 5)	Write Y or N	Write Y or N
Pain Score *At rest* (2 or more pain scores of 8-10 within 1 hour require review see page 5)	8 - 10 (RN/RM)	8 - 10
	5 - 7	5 - 7
	0 - 4	0 - 4
Blood Glucose Level (mmol/L)		
Initials		

SA Health
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SEE PAGE 1 - SECTION D

Date	Time	GLASGOW COMA SCORE: Eyes Open	Best Verbal Response	Best Motor Response	GCS TOTAL /15	PUPILS Right: Pupil Size	Pupil Reaction	PUPILS Left: Pupil Size	Pupil Reaction	LIMB STRENGTH Arms: Normal Power	Mild Weakness	Severe Weakness	No Response	LIMB STRENGTH Legs: Normal Power	Mild Weakness	Severe Weakness	No Response	NEUROVASCULAR Limb: Colour	Temperature	Movement	Sensation	Pulse	Capillary Refill	Pain

NEURO-VASCULAR LEGEND
Colour - pink, pale, cyanotic
Temperature - hot, warm, cool, cold
Movement - present, decreased, absent
Sensation - present, decreased, absent (tingling, numbness)
Pain - mild, moderate, severe

Date	Time	Comments / Remember to sign all entries including designation

Assessments

PUPIL SCALE (mm): 1, 2, 3, 4, 5, 6, 7, 8

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FLUID BALANCE CHART

Start Date: ..../........../.......... Fluid Restriction: ....

TIME	INPUT: Oral							Progressive Input	OUTPUT: Urine		Progressive Output
sub-total											
sub-total											
sub-total											

Interventions or Review

Date / Time	Intervention or review (e.g. Urine Output, Increased frequency BGL's, O2 changes etc)	Patient, family/ carer concern	Physical state change	Mental state change	Name / Signature
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	